			1 - State Registrar	State of Marylar			of Health of Death	1	Reg	ene	07	03001
п	Physici	an	1. Decedent's Name (First, Middle, Last)	Smoot					ate of Death Ionth	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give str			4b. City. Toy	vn, or Location	of Death	2	4c. Count	07 ty of Death	10:40 pm
	Examir	ier		Extended Ca	re		FIMORE	0.000			imore	e Citv
*	Funeral Director	~	5. Social Security Number 6. Sex 102	7. Age (In yrs.		if Under 1 Y			ate of Birth fonth, Day, Y		9. Birthp Coun	lace (State or Foreign
	land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					1	0d. Inside City Limits
	Many III	to	Maryland Harford		ŀ	Harford	County	,				1 ☐ Yes 2 🛣 No
	or 28s	Funeral Director	10e. Street and Number			10f. Zip Co			10g	. Citizen of	What Coun	ntry?
	23a c	ralD	754 Towne Center Di	rive			21085			USA	4	
	er deg	nue		!. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent If Yes, specify	of Hispanic Or Cuban, Mexica	igin? (Specify Y	es or No- , etc.)		ce - Americ	
36	rs aft	by F	1 Never Married 2 Married  XX Widowed 4 Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WW	11	1□Yes 2⊠	No Specify:	:		Speci	ity: Whi	te
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23a or 28a-f ehow event, it e Micdical Examinational be mailised at	ted	15. Decedent's Educa	ition	16a. Dece	dent's Usual O	ccupation		16	b. Kind of E	Business/fno	dustry
215	- * 3	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) Colfege (1-4or 5+)	(Give	kind of work a DO NOT use r	lone during mos etired)	st of working				ŕ
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Maryland	should be filed within and Mental Hygiene. marked other then matic event, it a Mi	Be	17. Father's Name (First, Middle, Last) Charles W. Smoot					ers Name <i>(Firs</i> rgaret K		iden Suma	me)	
Ž	s 1 and 2 should I if Health and Meni Item 27 is marked other treumatic	2	19a. Informant's Name/Relationship (Type	Print)	19h Mailie	ng Address (Si		er or Rural Rou		ity or Tour	State Zin	Codo
	ulth ar 27 ts r treu		Jane E. Sweeney (N:					rive Jo		-		(2008)
Baltimore,			20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of	of T	Date			- City or To	own, State
Ë	nit. Pages ertment of f ortant: If its injury or o		1 □ Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	Gle	en Abbe	ey Mort	uary	2-7-200	)7 E	onita	, Cal	if.
Salt	Deperting Indiana Indi		21. Signature of Funeral Service Licensee	1	demort.	assahn	ddress of Facili Funeral	ity Home				
	\$0 <b>5</b> 6 8		MOHOLOUSSC	em	174	<u>401 Bel</u>	<u>air Rd.</u>	. Baltin			1236	
}	Physician /Medical		Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	n. Do not ent	ter the mode of	dying, such as	cardiac or resp	oratory arres	•	ε	Approximate Interval Between Onset and Death An Kacily
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એ· •	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	ruence of):							
68760,	ate be executed hysician and he burial-transit	icai Exa	resulting in death) Last	Due to (or as a consec	uence of):							
687	ificate g phy: es the		d.									
.O. Box	that the death certificate be executed led by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. ff yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	Ideath 3[	Ectopic pregn Other (specif					ate of delive	ory Day Year
<u> </u>	es that gned b be deta	by Pt	Part ff. Other significant conditions contr	ibuting to death but not res	ulting in the u	nderlying caus	e given in Part I	1. 2	3e. Did toba	co use cor	ntribute to th	ne cause of death?
ğ	w require been sig should b								1 🗌 Yes	2 No	3 🗌 Prob	ably 4 Unknown
al Records,	The far ate has page 2	Completed							4a. Was an autopsy performe	24b.	Were autoprior to condeath?	psy findings available impletion of cause of
of Vital	Physician: This certificate ral director, p	Be	25. Was case referred to medical examiner?	spital:			Other	e of Death (Che				
ō		To	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time of		Other: 4 Nu	ursing Home	S Residence Describe how			1)
on	Attending in death.	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐	. 1	763CIIDB IIOW	ingury occu	11.60	
Division	tel or Attendii s efter death. al Director; A ad in by the fu	Certification:	3 Suicide 6 Courd not be determined	28e. Pface of fnjury - At h building, etc. (Special	ome, farm, str y)			28f. Lo	ocation (Streetity or Town, S	et and Num State)	ber or Rura	l Route Number,
	Hospit 4 hour Funer ely fille	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cien: To the best of my known: On the basis of examinations and manner stated.	owledge, death	h occurred at the vestigation, in	he time, date an my opinion, dea	nd place, and du ath occurred at	ue to the caus the time, date	se(s) and m and place	anner as st , and due to	ated. the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	. / \			cense number		29d	. Date sign	ed (Month, I	Day, Year)
	\		John s. (	ald m. T	)	3	4359 C	OHIO)	/	29	0.7	
	tt.		30. Name and address of person who com	pleted cause of death (Iter	n 23a) (Туре,	Print)	2 .00	ottio) ere, Ma	1 1			
2	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	M WOUL	evasor,	DATIME	re, Ma	ryland	2/2	18	
	Registi		FEB 0 2 200	17 December	de de	anoth y		6	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Sikri January 28 0145 2007 Kamla /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ballimore Cil Hopkins Johns Birthplace (State or Foreign Country) Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🕅 F Oct. 14, 1934 Director 385-54-9991 Pakistan Usual Residence of Decedent 10c. City, Town or Location 3a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🙀 No Director Maryland Montgomery Silver Spring 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20905 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must t 6 Windmill Court United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian-Indian ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) <u>;</u>+ Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ram Lal Mehndiratta Dharamwati Taneja 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Windmill Court, Silver Spring, Maryland 20905 Om P. Sikri/Husband 20b. Place of Disposition (Name of Montgomery Crematory or other place)

20c. Location - City or Town, State Bethesda, Maryland

20c. Location - City or Town, State Bethesda, Maryland

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20c. Location - City or Town, State Bethesda, Maryland

20c. Location 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardio ul menavo Due to (or as consequence of minute disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner requires that the death certificate be executed Henatic and use as the burial-tra Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4□Pregnant at time of death P.O. detached 9 Unknown 9 Unknown is been signed by the should be detachε Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown cate has been a page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

FEB 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES -000

The Johns Hoykus Hoyital 600 N. Walke St. Baltimore, MD 21287

07-00734 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Merle E. Stout, III 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 26, 2007 HII Stout ∩4∩1 hrs Medical Examiner Ε. Merle c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Director 39 Country) 03/04/1967 220-98-0616 1 X M 2 F NC Usual Residence of Deceden 10d Inside City Limits 10c. City. Town or Location 10a. State 1 Yes 2 X No Pasadena 28a-f show Anne Arundel Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-5 sho Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 USA 1110 Woodlawn Avenue 14 Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S must be Armed Forces? White, etc. Never Married 2 Yes Specify: White If Yes, Give Year Yes 2 X No specify. 3 Widowed 4 XDivorced Examiner δ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) event, the Medical Baltimore, MD 21215-0036 Construction Carpenter 12 1B.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rew Marv æ Merle E. Stout Jr. 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ 1110 Woodlawn Avenue, Pasadena, MD 21122 Merle E. Stout Jr. (father) ent of Health a 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Jan. Date 31 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 2007 Baltimore, Maryland Department of Important: injury or other Donation 5 Other Specify 22. Name and Address of Facility Foneral Service Licensee Stallings Funeral Home, <u>3111 Mountain Road, Păsadena, MD 21122</u> Approximate Interval er the disease, or come chitors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on ac Between Onset and /Medical Narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical X UNPENDED <sup>AMEN</sup>#25a,27,28a-f, perME, g864, 2/8/07 II attending physician for use as the burial certificate be Division of Vital Records, P.O. Box 68760. 23d Date of deliver IE EEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth Day Year 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? signed ò 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings avaitable prior to completion of cause of autopsy After this certificate has death? performed' 1 🗸 Yes ✓ Yes 2 No 2 No 26 Place of Death (Check only one) 25. Was case referred to medical uneral director, Other<sub>4</sub> Nursing Home 5 Residence 6 DOA 1 V Yes 28d Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Pending 1 Yes 2 y No unknown the Fnd 1/26/2007 Fnd 12:00 am Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State) 7735 B&A Road determined found in residence Pasadena. Homicide 29a Certifier

To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: After this cerifi

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29c. License number

29b Signature and title of certific Plista

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E

January 27, 2007

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day Year FEB. 0 State 2 2007 Registrar

Melissa Brassell, MD



g (Che one)

		•	For State Registrar	State o	f Marylar		artment of I		d Mental H	ygienę Reg. No:		03005
	Physici	an	1. Decedent's Name (First, Middle, Mildred Eliz		roff				2. Date of D Month		27 Year	3. Time of Death
1	/Medic Examin	er	4a. Facility Name (It not institution, Bel Air Llealth	give street and nu	mber)	enter	4b. City, Town. Bel Air	or Location of C	Death	40.	County of Death	<u></u>
	Funeral Director		194-16-2227	5. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of E	Day Vaar	9. Birthp Cour Penn	lace (State or Foreign htry) sylvania
	the Maryland 28a-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Hart 10b. Street and Number	arford	10c. Ci	ity, Town or Lo	Bel Ai	r		10g Citi	izen of What Cour	0d. Inside City Limits  1 ☐ Yes 2X No
99	Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland tent of Health and Mental Hyglene. Int: if item 27 is marked other then "naturel", or items 23a or 28a-f show yo or other treumatic event, it a Medical Examinar count be notified at	ra .	599 High Plains  11. Marital Status  1 Never Married 2 Marrie  3 🛱 Widowed 4 Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi	2∭Mo ve				n? (Specify Yes or Nuerto Rican, etc.)		U. S. A. 14. Race - Americ Black, White,	A. can Indian,
Baltimore, Maryland 21215-0036	d within 72 hour giene. er then "naturel"	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th Grade	Year or E Education grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire Homema	during most o	f working	16b. K	ind of Business/Ind	
ryland	nould be filed Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, L Griffith John 19a. Informant's Name/Relationshi	son		10h Mail	Add (Care	Ма	Name (First, Midd ry Seged) or Rural Route Num	7		Codel
nore, Maı	ages 1 end 2 st nt of Health and t: if item 27 ie n f or other treun		James Turoff (S 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation	on) 3 □Removal from	State	284 Place of Dispo	Sillery I sition (Name of matory or other pla	Bay Roa	d, Pasade Date	20c. Lo	Maryland ocation - City or To	21122 own, State
Baltin	permit. Page Department of Important: if any njury or once.		4 Donation 5 Other (Sp. 21. Signature of Funeral Service L		Da	2:		ess of Facility		Fune	eral Home	Maryland of Bel Air 1. 21014
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or o shock, or heart failure. List of limmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, litary, reading to arrangular cause. Enter Underlying Cause (Disease or injury)	a Due to	caused the dealeach line.  (or as a conse	DARSS quence of): 20PD	ter the mode of dy	ing, such as ca	irdiac or respiratory	arrest,		Approximate Interval Between Onset and Death
Box 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	in/Medical Examiner	that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, ou	(or as a conse	nancy	∃Ectopic pregnan				23d. Date of delive	ery
<u>Ф</u> О	res thet the deat signed by the att	by Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant condition	4□Preg 9□Unkr	nant at time of nown	death 5(	Other (specify)		23e. Di	d tobacco	Month use contribute to ti	Day Year he cause of death?
<b>Records</b>	aw requi s been s 2 should	Completed by		HTN					24a. W	Yes 26 tas an intopsy informed?	24b. Were auto	pably 4 Unknown
f Vital F		To Be Co	25. Was case referred to medical examiner? 1 \( \text{Yes}  20\) No		<del> </del>	∃ER/Outpatie	nt 3L DOA	ther: 4K Nurs	1 ☐ Yes  If Death   Check onling Home 5 ☐ Re	y one)	1 □ Yes	
Division of Vital Records,	r Attending ter death. irector: After by the fune	Certification:	27. Manner of Death  1/54 Natural  2 Accident  3 Suicide 4 Homicide  5 Pending investig 6 Could n determin	ot be 28e. Plac	of Injury oth, Day Year) e of Injury - At I ling, etc. (Spec	28b. Time of Injury home, farm, st	W	]Yes 2□No	28f. Location		nd Number or Rura	al Route Number,
	To the Hospital o within 24 hours ef To the Funerei Di completely filled in	edical	29a. Certifier 12 Certifying (Check only 2 Medical E	xaminer: On the l	e best of my kr pasis of examin nner stated.	nowledge, dea nation and/or in	th occurred at the evestigation, in my	time, date and opinion, death	place, and due to the control occurred at the time	he cause(s ne, date an	) and manner as s d place, and due to	stated. the cause(s)
	To t with. To t com	M	5	M, D:			D2		5	)):	ite signed (Month,	
	5		30. Name and address of person v SHILPI KHOS  31. Date filed (Month, Cay, Year)	s4 2	26 F	1AYS	ST # 10	2 /B	SEL A	IR,	MD 21	014
	St: Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 2		Registrar's Sign	A A	anto					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician **...** Month Alyce Clare Timchalk 7:40 AM Jan 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 Director 236 46 8556 76 Dec 11. 1930 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ No Directo Prince George's Maryland Temple Hills 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? rai", or Items 23a or Examiner must be r 6503 Summerhill Road 20748 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Types 2 No Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Tx txto ģ lf **Ye**s, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Bell Beatrice M. MacDonald ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Timchalk (Husband) 6503 Summerhill Road, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 6, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If it any injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemeterly Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Septifice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD mo0257 20735 )aus (1) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to or as a consequence of): Examiner CON Sequentially list conditions, if any, leading to immediate cause Enter Union, in Cause (Disease or injury nsequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? ∕es 2 □XNo certificate 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA ္က 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manne of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one)

241

State Registrar

29b. Signature and

ame and addre

32 Registrar's Signature 31. Date filed (Month, Day, FEB 02

of person who completed cause of death (Item 23a) (Type, Print

**ORIGINAL** 

50

29d. Date signed (Month, Day, Year) 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 9.50 AM Traversari Judith 27, 2007 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Boultimore Washington Midical Anne If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🛛 F 170-32-0341 Director 19 Dec. 1938 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 8104 Pineberry Court Unit 818 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Secretarv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angeline Mary Gurm Yanketis Anthony ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7818 Fox Farm Lane, Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st
Department of Health and
Important: If Item 27 Is n
any injury or other traun (daughter) Nina M. Traversari 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 29 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MAryland 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc 2007 21. Sign tule of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PHICAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exami that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? on 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: Certificati 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 15149

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State Registrar ress of person who o

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31. Date filed (Month, Day,

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leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		•	1 State of Maryland		artment of He			enê () () 7	03008						
1	4 8		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death						
П	Physici		Amy Marie Turley				Month O1	Day Year 27 2007	5:09p <sup>M</sup>						
2	/Medio Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat							
	Exami	-	Washington Adventist Hospital		Takoma	Park		Montgom	erv						
100	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)		If Under 24 Hrs.	8. Date of Birth		hplace (State or Foreign untry)						
п	Director		222-72-4173 1□M 2対F 27	Yrs.	Months Days	Hours Min.	(Month, Day, 12-27-1		DE DE						
66.5	ס		Usual Residence of Decedent												
	how			, Town or Lo					10d. Inside City Limits						
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	if th	Director	10e. Street and Number		10f. Zip Code	20050	10	g. Citizen of What Co	untry?						
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow event, it is Medical Exaction transitied at	ai	1801 Metzerott Rd.			20853		USA							
	de de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?	5. 13. \	Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit							
98	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 23 No If Yes, Give		1 ☐ Yes 2√⊟√No	Specify:		Specify: W	hite						
g	uraf.	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	11 5											
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2	Hygie Hygie other		17. Father's Name (First, Middle, Last)			8. Mother's Name	(First, Middle, M	aiden Sumame)							
ano	be data	Be	Kenneth T. Turley				ouise Hi								
Maryland 21215-0036	d 2 should be f th and Mental I 7 is marked of traumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)		City or Town, State, 2	7in Code)									
Ma	d2 s h an 7 is trau		Kenneth T. Turley/father		Mills St A										
a)	Health tem 27 tother tra				44				Town, State						
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 900.		1 ☐ Burial 3 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)												
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Ba	Department of the popular in the pop		mo135		33 Gist Av				tion Service						
			23a. Part1. Enter the disease, or complications that caused the sath						Approximate						
			shock, or heart failure. List only one cause on each line	الما الم	or the made of string,	a 01 a 71 1	, respiratory arm	1121+	Interval Between Onset and Death						
	Physician		Immediate Cause (Final disease or condition resulting in death)												
	/Medical Examiner														
Bell		-	Sequentially list conditions, fam. leading to immediate  Due to (or as a cons sence of												
$\overline{T}$	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	y.											
V	ate be executed obysician and the burial-transit	xan	that initiated events c	ence of):											
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9 x	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnal	ncv				23d. Date of de	ivery						
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o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown												
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ö	w requ	Completed	111110 m 20 - 12610				24a. Was an	24h Wara au	stoney findings available						
3e(	has has	E E	- PRO MACIO				autopsy	prior to	utopsy findings available completion of cause of						
<u></u>							1□ Yes 2	No 1 ☐ Yes	2 □ No						
Z.	hysician: The la his certificate has I director, page 2	Be	25. Was case referred to medical examiner?  Hospital:			26. Place of Death									
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	ling I. After funer	lo Lo	1 ¬Natural 5 □ Pending (Month, Day Year)	Injury	Work?	as 2 🗆 No	zod. Describe not	w analy occurred							
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Ì	or A after Direction by	rtif	4 Homicide determined building, etc. (Specify	)	eer, ractory, office		City or Town,	State)	arai riobig riambor,						
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ŏ	29a. Certifier A⊠ Certifying Physician: To the best of my know	wiedne desti	n occurred at the time	date and place	and due to the co-	use(s) and manner a	stated						
	24 h	edical	(Check only one)    Check only one)   Check only one)												
	o the	Me	29b. Signature and title of certifier	(	29c. License	number	29	d. Date sig ed (Mont	, Day,, r)						
	F 5 F ŏ	Ī			(	614	7	1/201	11						
			30. Name and address of person who completed cause of death (Item	23a\ /Tunn	Print)	011		1/4/	J						
	10		Nasreen M. Kango MD 7610 Carrol			ark MD 20	1912	1							
	Q Q	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signal		. rakuma I	ALK 1347 Z1	,,,,	ι							
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	For State of Maryland / Department of Ho State Registrar  State of Maryland / Department of Ho Certificate of E	Death Reg. No. 2007 03009										
Physician /Medical	Joyce Ann Williams	2. Date of Death January 30, 2007 ear  1:48P M										
Examiner Funeral	Facility Name (If not institution, give street and number) 4b. City, Town, or Lothian ocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Anne Arundel  If Under 24 Hrs.   8, Date of Birth   9, Birthplace (State or Foreign)										
Director	77-68-5923 1□ M 2♥ F 55 Yrs. Months Days	Hours Min. (Month, Day, Year) Country) Feb. 2,1951 Washington DC										
ryland how	. State 10b. County 10c. City, Town or Location	10d. Inside City Limits										
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at eted by Funeral Director	ryland Anne Arundel Lothian Street and Number 10f. Zip Code	1 ☐ Yes 2 ☐ No 10g. Citizen of What Country?										
st be n	209 B., Street 207											
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Marrital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  1 □ Yes 2 □ No Year or Dates:  1 □ Yes 2 □ No \ Year or Dates:	ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.)  Specify:  14. Race - American Indian, Black, White, etc.  Specify: White										
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rauma	- 1.77	and Number or Rural Route Number, City or Town, State, Zip Code)										
other 1	. Method of Disposition 20b. Place of Disposition (Name of	·										
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Depart Import any Inj once.	Resurrection Cemetery Feb 3,2007 Clinton, Mary Signature of Funeral Service Livensee    Down D Down   Mooder   Specify   Property   Property											
g physician and as the burial-transit as the burial-transit and ledical Examiner	mediate Cause (Final ease or condition ulting in death)  a. Due to (or a. a)consequence of):  puentially list conditions, ny, leading to immediate the first line through use (Disease or injury tinitated events ulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
for use	PEMALE: b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year										
been signed by the should be detached leted by Physic	t II. Other significant conditions contributing to death but not resulting in the underlying cause given	en in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Xes 2 No 3 Probably 4 Unknown										
cate has been s page 2 should		24a. Was an autopsy autopsy performed?  1 Yes 2 No										
s certifi director	Was case referred to medical examiner?  1 Yes 2 No Other	26. Place of Death (Check only one) er: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)										
rth. r: After this c e funeral dire ation: To	Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury 1. Natural 5 □ Pending (Month, Day Year) Injury Work											
within 24 roles are location.  To the Funeral Director, After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)										
thin 24 hour the Funer ompletely fill	a. Certifier  (Check only one)  **Descripting Physician: To the best of my knowledge, death occurred at the time of examination and/or investigation, in my operand and manner stated.	ne, date and place, and due to the cause(s) and manner as stated.  pinion, death occurred at the time, date and place, and due to the cause(s)										
To th comp	Signature and title of certifier  MD  29c. License  243	29d. Date signed (Month, Day, Year) 3276 JAN . 31, 2007										
10		oad Suite 106 Upper Marlboro, MD 20772										
State	Date filed (Month, Day, Year)  32. Registrar's Signature											

DHMH 17 Rev 1/2001

ORIGINAL

	1	State of Maryland / Department of Health and Mental Hyglene  1 - State of Maryland / Department of Health and Mental Hyglene  Certificate of Death  2 Date of Death  3. Time of Death
Physicia /Medic	in	JAMES JOHN WETZEL  Month  January 29, 2007  6:20 p
Examin	er	4a. Facility Name (If not institution, give street and number)  Severna Park Center  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  14 b. City, Town, or Location of Death  Severna Park  Anne Arundel  7. Age (In yrs. last birthday)  15 Under 1 Year  16 Under 24 Hrs.  16 Date of Birth Park  17 Center of Security Number  18 Date of Birth Park  19 Dirth Park  19 Dirth Park  10 Center of Death  20 Center of Death  21 Center of Death  22 Center of Death  23 Center of Death  24 County of Death  Anne Arundel  25 Social Security Number  26 Center of Death  27 Center of Death  28 Date of Birth Park  28 Date of Birth Park  29 Dirth Park  20 Center of Death  30 Death  40 Death  41 Death  42 County of Death  Anne Arundel  43 Death Park  44 Death Park  45 Death Park  46 Death Park  47 Death Park  47 Death Park  48
Funeral Director		470-22-7859 XX M 2 F 80 Yrs. Months Days Hours Min. Aug. 27, 1926 Minnesota  Usual Residence of Decedent
Marylan a-f ehow	tor	Maryland Anne Arundel Severn 1□Yes 3€N
th with the 23a or 28i	al Director	10e. Street and Number10f. Zip Code10g. Citizen of What Country?788 Martin Court21144U.S.A.
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mantal Hygiene. Importent: if Item 27 is marked other then "naturel", or items 23s or 28s-f show any Injury or other treumatic event, the Mudical Examinating the nutified at page.	by Funeral	11. Marital Status  1
within 72 house. Then "nature"	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) Grade 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Analyst  16b. Kind of Business/Industry  Federal Government
d be filed withing antal Hygiene.	Be	17. Father's Name (First, Middle, Last)  Bernard John Wetzel  18. Mother's Name (First, Middle, Maiden Surname)  Blanche Jennison
end 2 should be file salth and Mental Hy n 27 le marked oth	욘	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  James John Wetzel, II / son  788 Martin Court Severn, Maryland 21144
Pages 1 er nent of Hea nut: if Item:	İ	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  MD National Mem. Park 02/02/2007  Laurel, Maryland
permit. Pages 1 e Department of Hes Importent: if Item any Injury or othe		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland 20707
Physician /Medical Examiner bhysician and physician and the punial-transit	ai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
death certifi e attending od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month Day Year 1 □ Yes 2 □ No 9 □ Unknown
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e law has b	Completed	24a. Was an autopsy findings availat autopsy performed?  1 Yes 2 7 No 1 Yes 2 7 No
licien: certific rector.	Be	25. Was case referred to medical examiner?  Cither Others
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• # # E	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)
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	ate	29b. Signalure and title of certifier  29b. Signalure and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filled (Month, Day, Year)  32. Registrar's Signature  33. Date filled (Month, Day, Year)
Regis		FER 0 2 2007 James 13 James

Examiner The law requires that the death certificate be executed nding physicien and use as the burial-fransit Division of Vital Records, P.O. Box 68760, within 24 hours after To the Funersi Dire

**Physician** 

/Medical

Examiner

10a. State

Direct

Funeral

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Completed

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**Funeral** 

Director

if Health and Mental Hygiene.
Item 27 is marked other then "neture!", or items 23e or 28a-f ehow other treumstic event, the Modical Example market by notified at

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**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

death with the Maryland

Cause (Disease or injury that initiated events resulting in death) Last	. Evastage V	disland	3Mont		
	Due to (or as a consequence of): d	as cular	grofts	3 max	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant conditions co	23c. If yes, outcome of pregnancy  1 Urive birth 2 Fetal death 3 Ectopic  4 Pregnant at time of death 5 Other  9 Unknown	pregnancy (specify)	23d. Date of d Month	lelivery Day Year	
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying ANCOMY CIN Result	ond Enterococ		to the cause of death?  Probably 4 □Unknown	
MRSA (Me	thicillin Remotor	Steph awou	24a. Was an autopsy performed?  1 Yes 2 No 1 Yes		
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)		
1 Yes 2 No	Hospital: 1 \$\frac{1}{2} \text{ patient } 2 \subseteq ER/Outpatient } 3 \subseteq	DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Sp	pecify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred		
27. Manner of Death  1 Death  2 Accident investigation  3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,	
29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurr iner: On the basis of examination and/or investigal and magner stated.	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) and manner urred at the time, date and place, and d	as stated. ue to the cause(s)	
29b. Signature and title of certifier	$\sim 12 \text{ A}$	29c. License number	29d Date signed (Mo.	nth, Day, Year)	
Michel	It entain	D 214	38 Jones	M 78 7717	

CFENSE HAHWAM

State Registrar 31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Pr

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** JANUARY 4:15 A. 30, 2007 BARBARA A. WOLLSLAGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CITY N/A LORIEN FRANKFORD NURSING & REB. CEN. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 □ M 2 💢 F 4/23/1933 212-30-9409 MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 23a or 28a-f show or other traumatic event, the Midlical Examiner must be notified at 1 ☐ Yes 2X No Director MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 1638 MYAMBY ROAD USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? , or Items 11. Marital Status Black, White, etc. □Yes 2□No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: If Yes, Give Year or Dates: WHITE þ 3 Widowed 4 □ Divorced is marked other then "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DELI CLERK FOOD STORE 10TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ODG. DOROTHY VAIN JOHN WHITE ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTIMORE, MD 7408 VIRGINIA AVENUE THOMAS C. WOLLSLAGER/SON 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY, INC. 2/3/2007 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Steno813 tourtic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the inector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆ ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 212 No 1 Yes or Attending Physician: director, 26. Place of Death Check only one Be 25. Was case referred to medical examiner? Other: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after deat To the Funeral Diractor: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D 5601 oven 31. Date filed (Month, Day, Year) FEB 0 2 2007 32. Registrar's Signature State sole -Registrar

		1 - For State Registrar	State o	f Marylan		artment of H		nd Mental Hy	giene Reg. No	6001	03013			
		1. Decedent's Name (First, Middle,	Last)					2. Date of D	aath		3. Time of Death			
Physic /Medi		Yun Pao Yeh						Januar	y 30	y Year , 2007	4:00 P.M			
Exami		4a. Facility Name (If not institution,	give street and nur	mber)		4b. City, Town, or	Location of	Death	4c.	County of Death				
		11118 Pool Road					keysv:		1	altimore				
Funeral Director		5. Social Security Number 158-78-7524	5. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 100	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bi (Month, D DeC • 20	rth ay, Year) •190	9. Birth Cou	place (State or Foreign ntry) Su Zhou, Su, China			
pu		Usuel Residence of Decedent  10a. State 10b. County		10c Cib	y. Town or Lo	cation					10d. Inside City Limits			
Maryli eho	5		nore Coun		ockeys						1 ☐ Yes 2 🖾 No			
15 P	Director	10e. Street and Number				10f. Zip Code			10g Cit	izen of What Cou	nto/2			
3 with	ā	11118 Pool Road					1030			China	,			
deeth	Funeral	11. Marital Status		edent Ever in U.	S. 13.			in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Ameri	can Indian,			
iges 1 and 2 should be filed within 72 hours after death with the Maryland iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other then "naturel", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Giv	<sup>2</sup> ₩ No		r Yes, specify Cuba 1 ☐ Yes 2 <b>∑</b> No	sn, Mexican, Specify:	Puerto Rican, etc.)		Specify: Chi	etc. _nese			
hour	P P	15. Decedent's	Year or D	a165.	16a Dece	dent's Usual Occup	ation		16b K	ind of Business/Ir				
n n	Completed	(Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	durina most	of working	100. K	BIG OF DUSINESS/II	dustry			
i the	E	Elementary/Secondary (0-12) unknown	College (1 unknow			Home N	Maker			wn Home				
other vent.	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother	's Name (First, Middle	, Maiden	Sumame)				
Mental Hygiene, arked other the attc event, trees	10	Zi Hong Yeh					unkno	wn						
		19a. Informant's Name/Relationshi						or Rural Route Numb			Code)			
and 2 and 2 m 27 le		Mrs. Annie W. B	ishai (Fr		A STATE OF THE PARTY OF THE PAR	Pool Roa	ad C	cockeysvill			21030			
Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 🗆 Removal from	State C	emetery, crer	sition (Name of natory or other place		Date		ocation - City or T				
Thent:		4 □ Donation 5 □ Other (Sp.		H19			1	'eb.03,200'		llston,N				
permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Item 10 Injury or other tra		21. Signature of Funeral Service L	F- Ga	in la	Pe 23	2. Name and Addre 2. Paceful A. 3. 2. Pork I	ss of Facility Iterna Road	tives Fune Timonium,	erals Mar	Cremation	on Ctr.,P.A 21093			
		23a. Part . Enter the disease, or of shock, or heart failure. List of	omplications that only one bause on e	aused the death							Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	. +	Lenat	٥ نعلا	Jular 1	Carc	inama			Onset and Death			
/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):									
r	70	Sequentially list conditions,	b	(ur as a cunseq	opened offi									
led nsit	Examiner	Sequentially list conditions, flany, leading to immediate cause. Enter Underlying Cause (Disease or injury												
execu n enc ial-tra	Exa	that initiated events resulting in death) Last												
The law requires that the death certificate be executed the has been signed by the attending physician end page 2 should be detached for use as the burial-transit	dical		d											
ng ph	Jedi	IE EENALE.												
death certific	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ectopic pregnancy	,			23d. Date of deliv				
e dea the at	Physician/Me	in the past 12 months?  1 Yes 2 No 9 Unknown		ant at time of de		Other (specify)				Month	Day Year			
uires that the de nisigned by the a lid be detached to		Part II. Other significant condition	e contributing to di	anth but not son	ulting in the	adachiaa aassa ass	an in Dant I	22 Did	tabaasa /		he cause of death?			
signe d be	l by	Hun	a tens	CXX	aiting in the u	ndenying cause givi	en in raiti.	_		No 3 Pro	_			
w requir been si should	etec	274	00(=	w.oll.	tun			-						
sicion: The law certificate has b irector, page 2 s	Completed	1 )(0)	300-	//				— 24a. Was		24b. Were auto prior to co death?	opsy findings available impletion of cause of			
n: The ficate or, pa		OF Man area referred to an effect						1 ☐ Yes	2 No		2 No			
Physicien: Physicien: rai director, i	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	la satisant O	FD/0	. 20 DOA Oth	0.00	of Death   Check only		- 00				
F E E	⊢	27. Manner of Death	28a, Date	of Injury	ER/Outpatier 28b. Time of	IL 3LI DOA	4   Nur	sing Home 5 Res 28d. Describe		6 ☐Other (Special for occurred	(y)			
fr. Afr.	ig I	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		th, Day Year)	Injury		k? Yes 2 ☐ N	lo						
l or Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location City or To	Street an wn, State	nd Number or Run a)	al Route Number,			
To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	(Check only 2   Medical E	xaminer: On the b	asis of examina	wladge death	hoccurred at the time vestigation, in my or	ne, date and pinion, death	place, and due to the cocurred at the time	eausa(s)	) and manner as s	flated. o the cause(s)			
thin 2 the mplel	Med	29b. Signature and title of certifier	and man	ner stated.		29c. Licens								
To co	_	Signature and title or certifier	a.ci	Jank	S		3 88 E	0		te signed (Month,				
,		20 Name and addison of the	ho associated a		100-1		2 00 6	20	4	( -0				
		30. Name and address of person w	W Tern				ppa	Bg L	etta	-1-0- عالت م	MD			
Sta	ate	31. Date filed (Month, Day, Year)	32. R	legistrar's Signa	and the same of the						583			
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State of Maryland /	Department of He	ealth and Me	ental Hyd	niene.	IU

			1 - For State Registrar	State of Ma	•		ate of L			Reg. No		
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath Da	y Year	3. Time of Death
	/Medic		Donald Quincy Yo						01	30	2007	06:01p M
	Examin	er	4a. Facility Name (If not institution, giv	·	1	}		Location of Deat	h	4c.	County of Death Montgon	orv
			Montgomery Gener  5. Social Security Number 6. S		(In yrs. last birthda		lney	If Under 24 Hrs.	8 Date of B	idh		
	Funeral Director			M 2□F	81 Yrs.	Monti		Hours Min.	8. Date of B (Month, D 02-1)	ay, Year) 1–192	2.5	place (State or Foreign PA
	land ow		10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	Mary Iled	ţo	MD Prince	George	Laure	<u>-</u> 1						1 ☐ Yes 2 🛣 No
	r 28s	irec	10e. Street and Number			10f.	Zip Code			10g. Cit	izen of What Cou	ntry?
	th wit	aiD	9010 Briar Croft	: Lane #201				20708		τ	JSA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than "natural; or items 23a or 28a-f ehow eny injury or other traumatic event, it a Madical Examinar must be couldied at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1∰Yes 2 □ N If Yes, Give Year or Dates: V			cedent of Hi pecify Cuba	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Amen Black, White, Specify: Whi	etc.
2	72 ho	ted	15. Decedent's E. (Specify only highest gra	ducation	16a. De	cedent's U	sual Occupa	ation	rking	16b. K	ind of Business/In	dustry
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yland	ntai H ed ot ed ot	Be	17. Father's Name (First, Middle, Last, Benjamin F. Yowe					18. Mother's Nar		e, Ma <i>id</i> en	Sumame)	
Ž	d Me d Me mark matic	၉	19a. Informant's Name/Relationship (		10b Ms	iling Addr	acc (Stroot a	Miriam and Number or Ru		hor City	Code	
Mar	th an		Donna Yowell Lev		6	_		95 Portl				(000)
ē,	Hee Itam		20a. Method of Disposition	, 10, daugnee	20b. Place of Dis				Date		ocation - City or To	own, State
Ē	Page: ento nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Chesapea			1	-02-07	H	Beltsvill	le, MD
Baltimor	mit. partm ports r inju		21. Signature of Funeral Service Licer					- 1		ral 8	Cremati	on Service
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. Box	death cer e attendir id for use	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death	3 □Ectopio 5 □ Other	pregnancy (specify)				23d. Date of delive Month	ery Day Year
ras, r	requires thet the een signed by th hould be detache	þ	Part II. Other significant conditions of	contributing to death bu	t not resulting in the	underlyin	g cause give	en in Part I.		tobacco (		ne cause of death?
ecol	s bee	Siete							24a. Wa	s an	24b. Were auto	psy findings available
	sician: The law certificete hes b irector, page 2 sl	Completed							1 Yes	ormed?	death?	mpletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Ho	Hospital:	• •□ EB/O		DO: Othe	26. Place of Dea			a Clau	· ·
o no	nding Phy th. : After this s funeral d	-	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		of	28c. Injury Work	at	28d. Describe		6 □Other (Specil ry occurred	y)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, . (Specify)	street, fac	ory, office		28f. Location City or To	(Street an own, State	nd Number or Rura )	ul Route Number,
	he Hospi in 24 hour he Funer pletely filli	edicai	29a. Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of niner: On the basis of and manner stat	examination and/or	ath occurr investigat	ed at the tim ion, in my op	ne, date and place pinion, death occu	, and due to the rred at the time	cause(s) , date and	and manner as s d place, and due to	tated. o the cause(s)
	To t To t	2	29b. Signature and title of certifier	UD.			29c. License	number		- 1	te signed (Month,	Day, Year)
			• IVVW				TXI	06319	6	_11_	31/07	
l	0+1		30. Name and awdress of person who	completed cause of de	ath (Item 23a) (Typ	e, Print)	Phi	lip bu	we C	(ne	4 MD	20832
,	Sta Registr		31. Date filed (Month, Day, Year)	32, Registra	r's Signature	beetle	9	V				

			1- State of Maryland	Department of Health and N Certificate of Death	Mental Hygiene
2	Physici		Decedent's Name (First, Middle, Last)     Emma A. Yonych		2. Date of Death Month Day Year JANUARY 31, 2007 Ø8:54A
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cente	4b. City, Town, or Location of Death	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last</i> 215-12-9231 83	birthday) Yrs.  If Under 1 Year Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) March 23, 1923 Maryland
	faryland show ed at	or	10a. State 10b. County 10c. City, T	own or Location	10d. Inside City Limi
	leath with the Marylar ns 23a or 28a-f show must be notified at	I Director	10e. Street and Number 620 Straffan Drive #201	10f. Zip Code 21093	10g. Citizen of What Country?
980	72 hours after death with the Maryland natural", or Items 23a or 28a-f show disal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after d f Health and Mental Hygiene item 27 Is marked other than "natural", or Item other traumatic event, the Medical Examiner.	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Administrative Assista	l l
yland 2		To Be Co	17. Father's Name (First, Middle, Last) William Heinecke	Cati	e (First, Middle, Maiden Surname) herine Lewis
, Mar	ges 1 and 2 sho t of Health and If item 27 is m: or other traum		Mr. Alexander Yonych/ Husband	620 Straffan Drive #20	al Route Number, City or Town, State, Zip Code) D1 Timonium, Md. 21093
timore	permit. Pages 1- Department of He Important: If iten any Injury or oth		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	etery, crematory or other place) Land Memorial Pk. 2-3-0	Date 20c. Location - City or Town, State D7 Baltimore, Md.
Bal	permit Depar Impor any In		21. Signature of Fulgral Service Licenses	22. Name and Address of Facility Ruck Towson Fund 1050 York Rd. To	eral Home, Inc.
多,0928	Physician /Medical Examiner the pnual-transit	dical Examiner	23a. Part1. Enter the disease or complications that caused the death. If shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  2a. ISCHEMIC BD Due to (or as a consequent of the complex	WEL ce of): D UMBILICAL HERNIA ce of):	Interval Between Onset and Death
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۵.		þ	Part II. Other significant conditions contributing to death but not resultin  AORTIC STENOSIS	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes  No 3 Probably 4 Unknow
al Rec	The la ate has page 2	Completed	CONGESTIVE HEART FAILURE		24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No 2 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
Vit		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Illunpatient 2 ☐ ER.	Other:	n (Check anly one) me 5 ☐ Residence 6 ☐ Other (Specify)
Division or Vital Records,	After fune	Certification: To	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident Investigation	b. Time of Injury at Work?  M 28c. Injury at Work?  1  Yes 2 No	28d. Describe how injury occurred
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined 25e. Place of injury - At nome building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	n 24 ho n 24 ho ne Fune	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle and manner stated.	uge, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifler	29c. License number D3Ø263	29d. Date signed (Month, Day, Year)  01 - 31-07
	10		30. Name and address of person who completed cause of death (Item 23		BADDAL OND
	Sta	te	FRANCIS KHOO M.D. 7621 OS 31. Date filed (Month, Day, Year) 32 Registrar's Signature	LER DRIVE TOWSON.	MARYLAND 21204

DHMH 17 Rev 1/2001

Registrar

FEB 0 2 2007

/Medical Examiner Box 68760

Pnysician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

r than "natural", or iteme 23a or 28a-f eho the Medical Examinar must be notified at

Completed by Funeral Director

Be

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iled within 72 hours after death

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 le marked othin any july or other traumatic event 2008.

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24,

JANUARY

Baltimore, Mary

Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Physician/Medical P.O. I Completed this certificate has Be ၉ Certification: After filled in by the

Records, Division of Vital Hospital or Attending Physician: 24 hours after death. • Funerel Director: A within 24

4 Homicide

GLORIA

29a. Certifier 1🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State FEB 02

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

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MD

			For State Registrar		State	of Ma	ryland		rtment tificate				lental Hy	gien Reg. N	C 0 1	7	03	017
			1. Decedent's Name (First, I	Middle, La	st)								2. Date of De	ath			3. Time o	of Death
	Physici		FRANCES S.	ANDE	RS								Jan		•	(ear	5:15	AM
	/Medic Examir		4a. Fecility Name (If not inst.			number)			4b. City, 7	own, or	Location	of Death	Uan	_	c. County of		تانات	AM
			Genesis Hea	1th0	are -	. The	e Pir	nes		Eas	ton			Talbot			)†	
	Funeral		5. Social Security Number	6. 9	Sex	7. Age	(In yrs. last		If Under	Year	if Under		8. Date of Bir	rth		9. Birtho	lace (State	or Foreign
	Director		215-20-1388	_   1	I□M 2 <b>X</b> 1F		81	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da SEPT.	19,	1925	MA]	RYLANI	)
	D.		Usual Residence of Decede															
	how	_	10a. State 10b. Co	ounty			10c. City, T	Town or Lo	cation							1	0d. Inside (	
	Be-f	cto	MD	TA	LBOT			EA	STON								1 ∐ Yes	s 2X No
	ith th	Dire	10e. Street and Number						10f. Zip	Code				10g. C	itizen of Wh	at Cour	itry?	
	deeth with the Marylend me 23e or 28e-f ehow frount be notified at	Funeral Director	31856 KING	STON	_					2160					U	SA		
	er de	nue	11. Marital Status		12. Was De	Forces?		13. V	Vas Decede Yes, speci	ent of Hi fy Cubai	spanic Or n, Mexica	rigin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	o-	14. Race - Black,	Americ White,		
36	s aff	by F	1 Never Married 2 ☐ 3 XWidowed 4 ☐ Divo		I U Yes If Yes, 0 Year or	s 2∭ No Give	0	1	☐ Yes 2	( <b>X</b> No	Specify	:			Specify:	talan e	ਸਦਾ	
5-0036	be filed within 72 hours after ital Hygiene. d other then "neturel", or Ite event, Ita Wedical Examira	pa tr		edent's E		Dates.	1	I Sa Doord	ent's Usual	Ossuss				1.05				
ω <u>τ</u> .	in 72	Completed	(Specify only t	ighest gra	ade complete	<del>-</del>		(Give	kind of work	done d	lurina mos	st of work	ring	100.	Kind of Busi	ness/in	dustry	
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o o	Hyg Hyg other		17. Father's Name (First, Mi	ddle, Last		<u> </u>		1101	i i i i i i i i i i i i i i i i i i i	310	18. Moth	er's Nam	e (First, Middle	, Maide			<u> </u>	
ces Anders Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Iteme 23e or 28e-f show any injury or other treumatic event, its Medical Example from at the notified at ADGE.	To Be	PERCY STOOP	S							MA	ARTH	SKINN	ER				
S Z	should nd Men narke umatic		19a. Informant's Name/Reia		Type, Print)			19b. Mailin	g Address	(Street a			al Route Numb		or Town, St	ate. Zip	Code)	
e S	and 2 Balth a n 27 io		SUZANNE A.	HALS:	EY/DAU	GHTER							EASTO					
an ore,	s 1 a f Hea item othe	li	20a. Method of Disposition				20b. Plac	e of Dispos	sition (Nam	e of	- 1	and the state of	Date	_	_ocation - C		wn, State	
Francaltimore,	Pages nent of I int: If it		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			m State		-	atory`or oti Ma'Mi	•		7 1/1	17/2007	Tr A	STON,	MAT	OVT ANTE	,
H =	Departm Departm Importar eny Inju		21. Signature of Funeral Se				WOOD	22	Name and	Addres	s of Facili	ity						
ä	Departiment of the control of the co		JOHN T	≥.	MER	ER:	Cie	FF	ELLOWS	5. H	ELFE	NBEIN	N & NEW	NAM N N	FUNER	AL I	HOME F	'A
			23a. Part1. Enter the disease shock, or heart failure.	se, or com	plications tha	t caused t	the death.	Do not ente	or the mode	of dying	g, such as	cardiac	or respiratory a	rrest,	<u> </u>	O.I.	Approxima Interval Be	ite
Y	Physician		Immediate Cause (Final	List only	D	7		e.									Onset and	
	/Medical		disease or condition resulting in death)  a.   Due to (or as a consequence of):															
	Examiner		0															
	, ,	ner	Sequentially list conditions, if any, leading to immediate		b. Due t	o (or as a	consequen	nce of):										-
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events															
ó	e exe	Ë	resulting in death) Last		Due t	o (or as a	consequen	nce of):										
8760,	The law requiras that the death certificate be executed to has been signed by the attending physicien end age 2 should be detached for use as the burial-transit	dical			_ d				_							_		
မှ	ing p	Mec	IF FEMALE:	-										- 1				
Вох	ath ce	an/	23b. Was decedent pregnar		23c. If yes, o		of pregnancy E   Fetal de		Ectopic pre	gnancy					23d. Date		-	Wassa
	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		4□Pre 9□Unk		ime of deat	h 5□	Other (spe	cify)					Month	1	Day	Year
P.O.	d by d by letacl	Ph.		nditions :		death but	A A 10'-						00 011					
Vital Records,	w requiras that been signed to should be deta	b	Part II. Other significant co		rentie	o death but	t not resumi	ng in the un	ideriying ca	use give	in in Part	1.			use contrib			/
oro	neen Been Pould	eted	- Vascular	PCF.	- nuc								10	Yes :	2□No 3	∐ Prob	abiy 4	Unknown
ec	alaw nasb e 2 sl	Completed by	Aphasia										24a. Was	DSV	24b. We	ere auto	psy findings	available cause of
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/its	cien	Be	25. Was case referred to me examiner?	edical							26. Place	e of Deat	h (Check only	one)				
£	hysi this o	ဥ	1 ☐ Yes 2 No			Inpatien			3 DO		4/2\N	ursing Ho	me 5 🗆 Resi	idence	6 ☐Other	(Specify	1)	
Ę.	After Unera	on		ending		te of Injury onth, Day	Year) 28	3b. Time of Injury		c. Injury Work			28d. Describe	how inj	ury occurred	i		
Sign	tend death tor: /	cat		vestigatio ould not b					М		res 2 🗆	No						
Division of	or Al	Certification;		etermined	28e. Pla bui	ice of Injur ilding, etc.	ry - At home . <i>(Specify)</i>	e, farm, stre	et, factory,	office			28f. Location ( City or To	Street a wn, Sta	nd Number te)	or Rura	l Route Nur	nber,
ч	pital ours a erei (	1 1	29a, Certifier Cer	aifuin a Ot		h - h - h - h												
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Me	dical Exa	miner: On the	basis of e	examination	and/or inv	estigation,	in my op	e, date ar sinion, dea	nd place, ath occur	and due to the red at the time,	date ar	s) and mann nd place, an	ner as st d due to	ated. the cause(	s)
_	of thin	Me	29b. Signature and title of c	ertifier		7/2			29c.	License	number			29d. D	ate signed (	Month,	Day, Year)	
	->-0				MA	180	Len ,	NI			025	933	3		1.10	5.00	1	
			30. Name and address of pe	rson who	completed co	use of do	au (item 2	3a) (Tuno I	Print\			/			, ,,	-/		
	-8-		Millroslu	N	1	610	Dut	Claser =	21	ano	[	acto	n, MD	21	601			
	Sta	ate	31. Date filed (Month, Day,		. 1	. Registrar	r's Signatur	0	- 1 - B	7		יטןכטי	11/1					
	Registi	rar	JAN 1	<b>6</b> 200	A STATE OF THE STA	-	A.	A										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Arthur M. Alexander 25 14 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 □ F 83 Sep 20, 215-18-1115 Director 1923 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the M-dical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Washington 1 ☐ Yes 2 No Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 19508 Lorraine Terrace 21742 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 45-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify ş 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supermarket Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Guernon Alexander Bessie MArtin ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19508 Lorraine Terrace, Hagerstown, MD 21742 Robert S. Alexander son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Washington TWP 20a. Method of Disposition Department of Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Harbaugh Ch. Cemetery 01/29/07 Franklin Co., 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St. Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ne umoni Sequentially list conditions, if any, leading to immediate English and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 Ves 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2□№ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after dear To the Funeral Director completely filled n by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060396 25/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 AR 10 Registrar's Signal State

Registrar

			For State Registrar	State of	Marylar			nt of H te of L		and Me		giene Reg. No.	200	Townson or the same	0301	9
		- 1	Decedent's Name (First, Middle, Las	it)							2. Date of Dea Month	ath	, ,	'ear	3. Time of Death	ì
E.	Physici /Medic		PERCY RE	GINALD	BUR	TON					TANUAR		5,20		10:47 A	M
	Examin	er	4a. Facility Name (If not institution, give Holy Cross					, Town, or lver				4c.	County of MON		MERY	
200	Funeral Director		5. Social Security Number 6. Security Number 220-94-5394	ex 7. MM 2□F	Age (In yrs.	last birthday) Yrs.	If Und- Months	Days	If Under Hours	Min.	8. Date of Birtl (Month, Day Jan. 27	, Year)		Cour	lace (State or Fore itry) Yland	ign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	0d. Inside City Lim	its
	Maryl -f sho fied at	to	MD Howard	đ		Lä	aure	1							1 □Yes 2	No
	th the or 288 e noti	Director	10e. Street and Number				10f. Z	p Code				10g. Citi	zen of Wh	at Cour	itry?	
	ath wi		9090-M Moon S						723				U.S	•		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  ↑ Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? D <b>X</b> No		Was Dec If Yes, sp 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Spec n, Puerto R	ify Yes or No- lican, etc.)		14. Race - Black, Specify:	White,	etc.	
9	2 hou latura ical E	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Us	ual Occupa	ation	4 06		16b. K	nd of Busi	ness/In	dustry	_
2	ithin 7 ne. nan "n	Completed	(Specify only highest grades   Elementary/Secondary (0-12)	College (1-4	or 5+)	life.			unng mos )	t of working	9	-				
2	filed w Hygiel ther th		17. Father's Name (First, Middle, Last)			<u></u>	Coo	K	18. Mothe	er's Name	(First, Middle,		stau Surname)		1t	
Maryland 21215-0036	should be find Mental I	То Ве	Ulice Burt	on		40, 14-77	• • • • •	(2)		Mar	y Lee		ĺ			
<u>a</u>	and 2 sho ealth and n 27 Is ma		19a. Informant's Name/Relationship (7 Mary Burton (M			1	-				Route Numbe				MD 2072	3
re,	s 1 and 3 Health Item 27		20a. Method of Disposition	<u> </u>		Place of Dispo	sition (N	ame of		Da			cation - C			
altimore,	Pages ment of I ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			arklaw	n M	em P	ark	1/23	/07		kvil			
Balt	permit. B Departm Importar any Inju		21. Signature Funeral Service Licen	Mar	Lei										ME, P.A MD 2085	
OF BEAUTY	Physician		23a. Part1. Enter the disease, of comp shock, or heart failure. List only of Immediate Cruse (Final disease or condition	one cause on eac	h line.		ter the mo	de of dying	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death days	
	/Medical		resulting in death)		as a consec	nsion juence of):									days	_
3,	Examiner	١	Sequentially list conditions,	b. Sel	sis as a consec	wonee of:								_	days	
	nted Insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Erter Underhing Cause (Disease or injury that initiated events			us Ula	rer								weeks	
8760,	icate be executed physician and s the burial-transit		resulting in death) Last	0.	as a consec		<u> </u>									
687	ifficate g phys as the	edical		,d			-									
Vital Records, P.O. Box	The law requires that the death certific te has been signed by the attending p tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2□Feta nt at time of d	aldeath 3[	⊒Ectopic ⊒ Other (a	oregnancy specify)					23d. Date Monti		ery Day Year	
<u> </u>	w requires that the d been signed by the should be detached	/ Ph	Part II. Other significant conditions of	ontributing to dea	h but not res	ulting in the u	nderlying	cause give	n in Part I	*	23e. Did to	bacco i	ıse contrib	ute to th	ne cause of death?	_
rds	quires an sign uld be	ed by	Chronic re	nal fai	lure						1 □ Y	es 2	□ No 3	☐ Prob	ably 4XUnknow	wn
ဝင္ပဝ	ne law re has bee ge 2 sho	Completed	Atrial fib	rillati	on						24a. Was a		24b. We	ere auto	psy findings availal	ble of
<u>~</u>		Com									perfor	rmed? 2☐ No	de	ath?	2□ No	•
Zii	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o					
ō	유 무 등	. To	1 Yes No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗆 140		e 5 Resid				y)	
ion	Attending Physician: if death. ector: After this certifics by the funeral director, p	atio	Natural 5 Pending investigation		Day Year)	Injury	М		? ∕es 2□	No						
Division or	tal or Attu s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Zoe. Place of	injury - At h , etc. <i>(Speci</i>	ome, farm, str fy)	reet, facto	ry, office	Selet	28	Bf. Location (S City or Tow	treet an n, State	d Number	or Rura	I Route Number,	
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  Certifier  (Check only one)	ysician: To the be niner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurre ivestigation	d at the timen, in my op	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the o	cause(s date and	and manr d place, an	ner as s d due to	tated. the cause(s)	
	To the compound of the compoun	ž	29b. Signature and title of certifier				2	c. License		,					Day, Year)	
	3		of your	a Mr.				D3	2332	<u> </u>		Τ-	16-0	) /		
			30. Name and address of person who can Suresh K. Gupt					Ave	., ‡	220	, Silv	er	Spri	.ng	MD 2090	) 2
	Sta		31. Date filed (Month, Day, Year)	32 eg	istrar's Sign	ature	ask.									

		ľ	State of Maryland / Department of Health and  1 - State Registrer  Certificate of Death	d Mental Hy	giene Reg. No. 2007	03020
	Dhualai		1. Decedent's Name (First, Middle, Last)	2. Date of De	Day Yeer	3. Time of Death
	Physicia /Medic	_	Stanley Edwin Brewer  4a Facility Name (If not institution give street and number)  4b. City, Town, or Location of De	Janua	4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De  Easton	eatn	ialk	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Hrs. 8. Date of Bi	rth 9 Bir	tholace (State or Foreign
	Director		221-16-5692A X M 2 F 80 Yrs. Months Days Hours M	7-19-	1926 ReI	iance, DE
_	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	Manyli f aho	tor	MD Talbot St. Michaels			1X Yes 2 □ No
	h the	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	23a c	raiD	105 W. Maple St. P.O. Box 501 21663		USA	
	er dez Itema	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	o- 14. Race - Am Black, Whi	
336	urs aft	by F	1 ☐ Yes 2 ☐ No If Yes, Give \( \)  3 ☐ Widowed 4 ☐ Divorced Year or Dates \( \)  WITT		Specify:Wh	ite
) 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ahow tta Mudical Ezania er must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of the complete of the co	working	16b. Kind of Business	/Industry
121	within ne. han	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	orvicor	Telephon	0
	e filed valled v	ပိ			, Maiden Sumame)	<u>e</u>
اسار lan	ould be Mental arked c	To Be	Otho Gracen Brewer, Sr. Flora	Estell	e Bosley	
Struck	s 1 and 2 should be filed within 72 hours after death with the Marylan is Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other treumatic event, I to Mudical Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)  A. Faye Brewer (wife)  19b. Mailing Address (Street and Number or 105 W. Maple St.P	Rural Route Numb	per, City or Town, State,	ichael83 <sub>Md</sub>
	is 1 and 2 of Health of Health of Hem 27 I		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City o	
Baltimore,	permit. Pages Department of t Importent: If Its any injury or of		cemetery, crematory or other place)	9-2007	St. Micha	
Scalific	mit. Par partmen portent: / injury		21. Signature of Funeral Service Licensee , 22. Name and Address of Facility			
(- 8	permi Depa Impo any ir		R. Carroll Hur  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.	Tey Fun	eral Home <del>haels Md.</del>	, PC 21663
					arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. End Stage Renal disease Reveal disease are sufficiently in the condition resulting in death)	ase		yrs
	Examiner		Due to (or as a consequence or):			3
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c			
760,	te be executed ysician and ie burial-transit	cai E	pue to (or as a consequence of).			
	, Y 6		d			
Box 68	th cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of d	elivery Day Year
Э.	the att	by Physician/Med	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Yes 2 □ No 9 □ Unknown		World	Day 1 out
P.O.	that the ed by detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds	quires in sign		Lumber Osteomyelitis	10	Yes 2 No 3□F	Probably 4 Unknown
် လ	aw rec	Completed	3	24a. Wa	s an 24b. Were a	autopsy findings available completion of cause of
<u> </u>	Physician: The la r this certificate has ral director, page 2	Com		per 1 ☐ Yes	formed? death?	_40
V ita	ician: certifii rector,	Be	examiner?	Death (Check only		
<b>*</b>	Phys or this oral dii	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		sidence 6 Other (Sp how injury occurred	ecity)
jo	inding ath. r: Afte	ation	2 Accident investigation M 1 Yes 2 No			
Division of Vital Records.	or Atterder de linecton by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or T	(Street and Number or I own, State)	Rural Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Ce	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	lace, and due to th	e cause(s) and manner	as stated
	e Hos 124 ho ie Fun iletely	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred at the time	e, date and place, and di	le to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifie 29c. License number		29d. Date signed (Moi	
			1 B. LOMB D54488	-	1-15-2	
-	-20-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Rennet So Mb 219 5 Washington St	Easto	in, mis z	21601
	Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			_
	Regist		JAN 1 9 2007			

			State of Maryland / Department of State of Maryland / Department of Certificate of Certificate of State of Maryland / Department of Certificate of Certifica			ene 007	03021
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
ı	Physicia /Medic	al	Jessie Evelyn Beckman		January	28, 2007	1:00 A M
	Examin	er	Table ( a series )	n, or Location of Death		4c. County of Death	
			Oakland Nursing & Rehabilitation Oaklar  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth	Garrett 9. Birthp	place (State or Foreign
В	Funeral Director		220-38-0016 1 M 2 M F 88 Yrs. Months Day	ys Hours Min.	(Month, Day, March 18	B 1918 Mar	yland
	P		Usual Residence of Decedent			1	0d. Inside City Limits
	anylar ehow	٦					1 ☐ Yes 2 X No
	28a-f	Director	MD Garrett Oakland  109. Street and Number 10f. Zip Code	9	10	Og. Citizen of What Cour	ntry?
	3a or		5423 Gorman Road 21550	0	1	United Stat	es
	death	Funeral		of Hispanic Origin? (Spe Juban, Mexican, Puerto I		14. Race - Americ Black, White,	can Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If Item 27 is marked other than "neturel", or Items 23s or 28s-f show any injury or other treumatic event, Its Medical Examinar must be notified at ance.	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No			Specify: Whi	
ğ	72 hou		15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work dor	cupation ne during most of workit		16b. Kind of Business/In	dustry
Maryland 21215-0036	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ired)		O W	
2	filed w Hygier other th		12 Homemaker  17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N	Own Home	
anc	d be find he of	Be C	John Stever	Evelyn			
2	Should Me mark	၉	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Stre</i>		al Route Number,	City or Town, State, Zip	Code)
	nd 2 alth ar 27 is		John H. Beckman, Son 7855 Gorman	Road, Oakl	Land, MD	21550	
altimore,	of Head		20a. Method of Disposition  1 IX Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other parts)		Date	20c. Location - City or To	own, State
Ĕ	Page nent ant: H		4 Donation 5 Other (Specify) Pleasant Valley	Cem. 1/31	1/2007	Oakland, MD	
Balt	permit. Depart Import eny Inj		21. Signature of Funeral Service Licensee 22. Name and Adi	bui		rst Funeral Oakland, MD	
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of c shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	n rel g	neo-		Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):				
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	led nsit	nine	cause. Enter Underlying Cause (Disease or injury				
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8760,	cate be executed physicien and the burial-transit	dicail	d				
9	ntificating physics the	Jedi	IE CENAL E.				
Вох	death certifi e ettending   ed for use as	an/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
0	that the death certificed by the ettending I	Physician/Me	1 Yes 2 No 9 Unknown 5 Other (specify,	)			
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ds	quires n sign	d by	Alzhemens dementia		1 □ Ye	as 2. No 3 □ Prol	oabły 4 □Unknown
Vital Records,	s been si	Completed			24a. Was a		opsy findings available ompletion of cause of
æ	The lav	E			perform	ned? death?	2210
ita	ician: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?	26. Place of eath	h (Check only on	e)	
	Physician: this certific ral director,	P	1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA			ence 6 Other (Speci	fy)
Division of	ing P	i o	Terratural Scholiding	njury at Work? 1 □ Yes 2 □ No	28d. Describe no	ow injury occurred	
isi	Attending r death.	cat	2 ☐ Accident		281 Location (St	reet and Number or Rur	al Route Number,
Ď	after Direction by	Certification;	4 Homicide determined building, etc. (Specify)		City or Town	n, State)	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funarel Director: After this certificate hat completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in n and anner stated.	e time, date and place, ny opinion, death occurr	and due to the c red at the time, d	ause(s) and manner as a ate and place, and due t	stated. to the cause(s)
	To the I within 2 To the I complet	Me		cense number	2	9d. Date signed (Month,	Day, Year)
)	⊢≯⊢ŏ			42464		1/29/1	7
			30. Name and a press of person who completed care of death (Item 23a) (Type, Print)	101		1 1	1
			Sotiere Savopoulos, MD 255 N. Fourth St	., Suite 1,	, Oaklan	d, MD 2155	0
	St Regist	ate	31. Date filed (Month, Day, Year)  JAN 2 9 2007  32. Registrar's Signature				
	ricgist	-	A CONTRACTOR OF THE PROPERTY O				

			For State Registrar	State o	f Maryla		partment of I		nd Mental Hy	giene 2	007	0302
			1. Decedent's Name (First, Middle	le, Last)					2. Date of De	eath Day	Year	3. Time of Death
_	Physici /Medic		Elijah Brown,	Sr.					Januar		2007	10:45 P
	Examir		4a. Facility Name (If not institution		ŕ		4b. City, Town, o	or Location of	Death	4c. Coun	ty of Death	j.
	Andrew Land State of the Control		Berlin Nursing				Berlin		d Hm Lopi (n		rcest	
ł	Funeral Director		5. Social Security Number 244–32–0073	6. Sex 1 <b>2</b> M 2 ☐ F	7. Age (In yr. <b>78</b>	s. last birthda Yrs.	Months Days		Min. 8. Date of Bit (Month, Date Aug 24	ay, Year)	9. Birth Cou	pplace (State or Fore intry) NC
	P _		Usual Residence of Decedent		140- 6							
	arylar show d at	-	10a. State 10b. County			City, Town or	Location					10d. Inside City Lim 1 ▼ Yes 2 □ I
	he M 28a-f otifie	Director	MD Word	ester	1	Berlin	104 Zin Code			10g. Citizen o	f M/bat Cou	
	a or	Ö		od 1 Dun A	nta d	U111	10f. Zip Code 21811			0	SA	ntry?
	eath ns 23 musi	Funeral	509 Bay St., Qu	12. Was Dece	edent Ever in			Hispanic Origi	in? (Specify Yes or No		ace - Ameri	can Indian,
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1  Never Married 2  Mar	ried Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2 No e		If Yes, specify Cut  1 ☐ Yes 2 ☐ No		in? (Specify Yes or No Puerto Rican, etc.)	-	lack, White,	
Ö	hours tural"	d by	3 Widowed 4 Divorced	1	ates:	16a Do	edent's Usual Occu	unotion		16b. Kind of		
-5	"nat	lete	(Specify only highe	nt's Education est grade completed)		(Gi	re kind of work done  . DO NOT use retire	pation during most ( ed)	of working	160. Kind of	business/ir	laustry
12	withi iene. than the M	Completed	Elementary/Secondary (0-12)  3rd	College (1	-4or 5+)		Maso			Va	rious	
D	illed I Hyg other	Be C	17. Father's Name (First, Middle,	Last)				18. Mother	s Name (First, Middle	, Maiden Surn	ame)	
ah lan	uld be flenta rked ric ev	To B	Coy Brown					Mary	Wesley Bea	atha		
i j	shol		19a. Informant's Name/Relations	ship (Type. Print)		19b. Ma	iling Address (Street	t and Number	or Rural Route Numb	ber, City or Tow	n, State, Zi	p Code)
E ×	and 2 ealth n 27 I		Evelyn Watson/f	riend		P. (	D. Box 82	, Berli	in, MD 218	11		
Brown, Elijah Baltimore, Maryland 21215-0036	of He		20a. Method of Disposition 1    Burial 2 □ Cremation	3 □Removal from		Place of Dis cemetery, c	position (Name of rematory or other pla	ace)	Date	20c. Location	a - City or T	own, State
im	Pag ment ant:		4 □ Donation 5 □ Other (5		Ne		nel UMC Ce		/20/2007	Berli	n, MD	
3rc	ermit lepari npor ny ln		21. Signature of Funeral Service	Licenson		3	22. Name and Addr 	ess of Facility Natson	Funeral Ho	ome		
	4 0		23a. Part1. Enter the disease, o	Walson							01	A
			snock, or near failure. Lis	t only one cause on e	aused the de ach line.		13 0	_	_			Approximate Interval Between Qnset,and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. NIV	1405	10001	re Cere	des va	culer Di	scare		rews
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	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .								
ó	exec an an rial-tr		resulting in death) Last	Due to	or as a conse	equence of):						
8760,	icate be executed physician and s the burial-transit	dical		d								
9	ng ph as th	Med	IF FEMALE:								-	
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		oirth 2□Fe ant at time of	etal death	B Ectopic pregnanc DOTHER (specify) _	СУ			Date of delive Month	very Day Year
σ,	N requires that the dispension been signed by the should be detached		Part II. Other significant conditi	ions contributing to de	eath but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
r Sp	quire; in signid be	ed by	Metoskatic	· Ciru	<u>Ce</u>	an ce			1_	Yes 2 □ No	3☐ Pro	bably 4 Donkno
ပ္ထ	aw re	Completed	Chronic C	betrute	e Pa	ulius	my Di	500 × 7	24a. Was		o. Were aut	opsy findings availal
Ä	The late ha	E O							auto perf	ormed?	death?	ompletion of cause o 2□ No
ta	<b>hysician</b> : The law his certificate has b I director, page 2 s	Bec	25. Was case referred to medica examiner?	al				26. Place	of Death (Check only			
>	hysic nis ce I direc	To	1 Yes 2√1No	Hospital: 1 □	npatient 2	☐ ER/Outpat	ent 3 DOA		sing Home 5 ☐ Res	idence 6 🗆 C	ther (Speci	ify)
D C	ng P		27. Manner of Death  10 Natural 5 □ Pendi		of Injury th, Day Year)	28b. Time Injun	, Wo			how injury occ	urred	
sio	tendleath.	cati	2 Accident investi 3 Suicide 6 Could	not be				Yes 2□N				
Division or Vital Records,	al or Al after o Direct d in by	Certification:	4 ☐ Homicide determ		ng, etc. (Spe		street, factory, office	•		Street and Nui wn, State)	nber or Hur	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical C	29a. Certifier (Check only one) Certifyi Medical	Examiner: On the b	best of my k asis of exami ner stated.	nowledge, de nation and/or	ath occurred at the t investigation, in my	time, date and opinion, deat	I place, and due to the h occurred at the time	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
	With Com	Σ	29b. Signature and title of certific	7			29c. Licen	ise number		29d. Date sign	ned (Mogth,	, Day, Year)
	13		MAN	Lenk			1	0876	57	111	110	1
	100		30. Name and address of person	who completed caus	e of death (Ite	em 23a) (Typ	e, Print)	16	T	651	1 1	1- 100M
	<u> </u>		31. Date filed (Month, Day, Year	schillen 1	egistrar's Sig	nature	Market l	gues	y beingel	1760	not h	rc 1 174
100	Sta	ιte	and morning Day, Teal,	, JE. 11	3			/				

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** 0355 AM DULISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALISBURY COASTAL HOSPICE at the LAKE WICOMICO If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛚 F 79 SEPT. 1927 MARYLAND 213-22**-**9733 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director MARYLAND WICOMICO WILLARDS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 35815 WOODYARD ROAD 21874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** CLOTHING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAY LEWIS AGNES DAVIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELE L. BRADFORD/DAUGHTER 32520 CURLEY DR., MILLSBORO, DE. 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBunal 2 ☐ Cremation 3 ☐Removal from State 5 ☐ Other (Specify) NEW HOPE CEMETERY 1/21/07 WILLARDS, MARYLAND 4 □ Donation 21. Signature of Freneral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Metastatil **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death V Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce E. Carall. round 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29a. Certifier (Check only

26278

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coasted Haspie

State Registrar

		1 - For State Registrar	State of Man			of Hea	lth and M	lental Hyg		007	030	24
Physici	a ian	Decedent's Name (First, Middle, Last)				_		2. Date of Dea		20 Kear	3. Time of D	
/Medic		Elma W. Bo	*		T:-		coreco a state	January		20 <b>07</b> °	0553	М
Examir	ner	4a. Facility Name (If not institution, give s Harford Memoria				own, or Loc e de G	ation of Death			ounty of Death		
Funeval		5. Social Security Number 6. Sex		yrs. last birthday			Under 24 Hrs.	8. Date of Birth		Harford 9. Birth	place (State or F	-oreian
Funeral Director			52 -	0 Yrs.	Months		ours Min.	8. Date of Birth (Month, Day June / 19	<b>,</b> 191	6 Miss	issippi	
yland how		10a. State 10b. County	10	c. City, Town or L							10d. Inside City	
Sa-f	cto	MD Harford		Aberde	en						1X☐ Yes 2	□ No
nin 72 hours after death with the Maryland in "netural", or Iteme 23a or 28a-f ehow Medical Examinar must be notitied at	by Funeral Director	10e. Street and Number			10f. Zip (			1		en of What Cou	intry?	
ath v	- a	3512 Garrett Ct.				001				J.S.A.		
ab rei	n.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 ☒ No</li> </ol>	r in U.S. 13.	If Yes, speci	ent of Hispar fy Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ameri Black, White,</li> </ol>		
irs aff	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No S₁	pecity:		5	Specify: Afro	o-Americ	an
2 hou		15. Decedent's Educ	cation	16a. Dec	dent's Usual	Occupation	1		16b. Kind	of Business/Ir		
thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	done durin e retired)	g most of work					
ed within 72 hours af /giene. er then "netural", or t. Ita Medical Exam	Completed	12	2	Sel	f empl						Cosmotol	ogis
tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						e (First, Middle, i	Maiden S	umame)		
ould Men Marke	မှ	William Walls					auline					
nd 2 sh lith and 27 le π r trauπ		19a. Informant's Name/Relationship (Ty) Senora W. Haywood			ing Address Garre			al Route Number irdeen, N		Town, State, Zij 21001	p Code)	
s 1 ar f Hea ltem othe		20a. Method of Disposition	1	20b. Place of Disp	osition (Nam	e of		Date	20c. Loca	ation - City or T	own, State	
Pege ent o nt: If ry or		1  Burial 2  Cremation 3  R 4  Donation 5  Other (Specify)	emoval from State	Harford			2/3/0	7	Aber	deen, M	Maryland	E
permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: if Item 27 te marked other then "netural", or Iteme 23e or 28e-f ehov eny Injury or other traumatic event, Ira Modical Examinat must be notified at ODGe.		21. Signature of Funeral Service License		1 2/2-2	2 Name and Tarrin	Address of	go Fune	ral Home 21001-	2, P.	.A.		
Physician /Medical Examiner prijal-transit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	ATIM		in as cardiac	or respiratory arm	est,		Approximate Interval Betwe Onset and De	een ath
The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE:	ac. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pre □ Other (spe				23	d. Date of deliv Month	ery Day Yea	ar
uires tha signed I Id be det	b	Part II. Other significant conditions con	tributing to death but n	ot resulting in the	underlying ca	use given in	Part I.			e contribute to t	he cause of dea bably 4 🕱 Uni	
w req beer shou	ete	- SICHOLD IMINA	WS					24a. Was a	0	24h Wara auto	opsy findings av	aulablo
ding Physician: The law requir h, After this certificete hes been si funeral director, page 2 should I	Completed							autops perform 1 Yes	y ned?	prior to co death? 1 🗆 Yes	Mo	se of
sicia certi recto	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	о П <b>г</b> о:о		Othor		h Check only on				
Phys r this ral dii	<del> </del>	27. Manner of Death	28a. Date of Injury	2 ER/Outpatie		lc. Injury at		me 5 Reside			fy)	
ding F th. After funera	to	Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	м	Work? 1 ☐ Yes			,,			
l or Atten after deal Director: I in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, s	reet, factory,			28f. Location (St City or Town		Number or Run	al Route Numbe	r,
To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, i	edical C	29a. Certifier Certifying Phys	ician: To the best of mer: On the basis of exa and mapmen stated	amination and/or i	th occurred a rivestigation,	t the time, d	late and place, on, death occur	and due to the cared at the time, d	ause(s) a ate and p	nd manner as s lace, and due t	stated. o the cause(s)	
Fo th Mithin Fo th	Me	29b. Signature and title of certifier	1/-1	,	29c.	License nur	mber	2	9d. Date	signed (Mor/th,	Day, Year)	
. >= 0		1/12-20 1	Brankla	del		1110	200		11	22/15	7	
3		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type	Print)	HINI	pli	4/1/0	10	7/0'74	1	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Sideature	No B	016110	0104	in a for	1	10/0		
Registr		31. Date filed (Mosts Day, Year) 2007	Alle Come of	15 /5/20	Por and			,				

Exp: 0553 1/28/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® [ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle, Last) CASEY HESTER 4:03 P 2007 **JANUARY** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER GLEN BURNIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Day | Hours | Min. | DEC 16 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months 1918 SOUTH CAROLINA 1□M 2♥F Yrs 247-24-4121 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County 1X Yes 2 □ No UPPER MARLBORO PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20772 3901 BISHOPMILL PLACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Marned BLACK 1 ☐ Yes 2 🖾 No Specify 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE PRESSER 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HESTER MOLLETTE JERIMIAH GEDDIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3901 BISHOPMILL PLACE UPPER MARLBORO, MARYLAND 20772 MARY H. BROWN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND 1/22/2007 4 Donation 5 Other (Specify) WOODLAWN CEMETERY J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 515 VO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VITER Due to (or as a consequer ce of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy 1 ☐ Yes 2010 26. Place of Death | Check only one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Xir patient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending Injury

Examiner Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and P.O. Box 68760 Physician/Medical the a à ias been signed b Division of Vital Records. þ Completed has certificate Attending Physician: After this certification, funeral director, Be Certification: To death. To the Mospital or Attend within 24 hours after death. To the Funeral Director: the filled in by

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

an "naturel", or Iteme 23a or 28e-f ehow Medical Examiner must be notified at

Director

Funeral

by

Completed

Be

with the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel, or Item any injury or other traumatic event, IL. Mantalland

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Scertifying Physician: To the best of my knowledge, death occurred at the time. Sate and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 29c. License number

d address of person who peripleted cause of death (Item 23a) (Type, Print)

State Registrar

completely

Medical

31. Date filed (Month, Day, Year) JAN 22 2007

0



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amendment item#18,QACHD,1/30/07,tw Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 8:53 PM DOOLITTLE ROBERT 20 07 17 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ARUNDEL If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 041-26-7522 72 MAY 12, 1934 CONNECTICUT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow the Mudical Examiner must be notified at 1 Yes 2 No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 items 23a 135 TANNER'S POINT ROAD 21666 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Kg Yes 2 75 No If Yes, Give 7 Year or Dates: 1956-1959 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 natural, or 1 Yes 2 No Specify: WHITE Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Flementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygienu Important: if Item 27 is marked othar tha any Injury or other treumatic awant PHARMACY 4 PHARMACEUTICAL REPRESENTATIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CATHERINE -LOCHEAD ARNOTT LOCHHEAD JONATHAN EDISON DOOLITTLE ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN B. DOOLITTLE/WIFE 135 TANNER'S POINT ROAD, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State JANUARY 24, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 STEVENSVILLE, MARYLAND BROADCREEK CEMETERY 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death nmediate Cause (Final Immediate Cause (F disease or condition resulting in death) Physician RESPIRATORY FAILURE /Medical Due to (or as a consequence of) Examiner NEUROMUSCULAR NISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed use as the burial-transli ENCEPHALIT YME Due to (or as a consequence of): nding physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 Yes 2 0 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospitel or Attanding with 24 hours after death.
To the Funeral Director: After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) à 4 Momicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062296 13/2 MD

State

Registrar DHMH 17 Rev 1/2001 ANNE

ARUNDEL MEDICAL CENTER

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

FORDE

Registrar's Signature

KIMBERLY

31. Date filed (Month, Day, Year)

JAN 2 2 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 2130 M Physician January 16, Katherine Tawney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANCHORAGE NURSING & REHABILITATION WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🖺 F 93 214-03-4755 12/29/1913 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or iteme 23a or 28a-f show any injury or other traumatic event, Ita Madical Exercises. 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 1¥1Yes 2 No Be Completed by Funeral Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 4782 Cardinal Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: white If Yes, Give Year or Dates: 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Therapy Occupation Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Franklin Tawney Sr. Jennett Van Sant ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tawney A. Kraus/daughter 4782 Cardinal Dr., Salisbury, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 1/18/07 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Clina. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) this certificate has been signed by the rail director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No Attending Physician: After this certification funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 1 🗹 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō 1 Centifying Physician: To the best of his knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 347044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) s. DIV NATE SAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2007 1:30 January 16 Manard Lamar Ellis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1⊠M 2□F March 26,1933 Virginia 73 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

United States

14. Race - American Indian,

White

Transportation

Black, White, etc.

Examiner 9420 Bethel Road Social Security Number **Funeral** 227-36-5336 Director Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. Director Frederick Frederick Maryland 10f. Zip Code 10e. Street and Number 21702 9420 Bethel Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gracie May Nichols Graham Ellis ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) **Physician** /Medical **Examiner** 

Physician

/Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed attending p ed by the detached within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

State Registrar

Elhamy 31. Date filed (Month, Day, Year)

2007

Genevieve R. Ellis	s / Wife	9420 B	ethel Road	Frede	erick, Ma	aryland	21702
20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □		20b. Place of Disposition cemetery, cremate	on (Name of ory or other place)	Date Januar	2001.	Location - City or	Town, State
4 □ Donation 5 □ Other (Specify		Resthaven M	em_Gardens	19, 20		ederick,	Maryland
21. Signature of Fun Hourvice Licen	1	162	ame and Address of Fa l Opossumto	wn Pike		eral Homick, Mar	es, P.A. yland 21702
23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused tone cause on each line	he death. Do not enter t	he mode of dying, such	as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a Metasto		null cell		cancei		Year
Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	consequence of):					
resulting in death) Last	Due to (or as a	consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	P ☐ Fetal death 3 ☐ Ed	etopic pregnancy ther <i>(specify)</i>	- 5.		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions of	ontributing to death bu	t not resulting in the unde	rlying cause given in Pa	art I.	1/		to the cause of death? Probably 4 ∐Unknown
					24a. Was an autopsy performed?	prior to death?	
25. Was case referred to medical			26. P	lace of Death (C	Check only one)		
examiner? 1	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	3 DOA Other: 4	Nursing Home	5 Residence	6 □Other (Sp	ecify)
27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day		28c. Injury at Work? M 1 Yes 2		d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of injubuilding, etc	ry - At home, farm, street . (Specify)	, factory, office	28f	Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the best of miner: On the basis of and manner sta	of my knowledge, death of examination and/or invested.	ccurred at the time, dat stigation, in my opinion,	e and place, and death occurred	d due to the cause at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s)
29b. Signature and title of certifier	Il mi	D	29c. License numb	8184	29d. [	Date signed (Mor	nth, Day, Year)
30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pr	W 7th S	treet 7	rederi	ck, M	D 21701

07-00758 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Adam Scott Fields 2007 1- For State Certificate of Death Registra Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 27, 2007 0632 hrs Medical Examiner Adam Scott Fields 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death Germantown Montgomery 13105 Alpine Drive if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Hours Months Davs Director 12/24/1977 124-60-6340 29 Country) 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show MD Montgomery Village Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number notified at United States 20886 19317 Transhire Road marked other than "natural", or items 23a event, the Medical Examiner must be noti ā 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2X No Yes White If Yes, Give Year 1 Yes 2 X No specify: Widowed Divorced Specify 3 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exa Completed College (1-4 or 5+) Elementary/Secondary (0-12) 2 Student Education 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be Anita Reichick Gary Fields 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19317 Transhire Road Montgomery Village MD 20886 Gary Fields - Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Clarksburg, MD 1/30/07 Garden of Remembrance Donation 5 Other Specify 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 1091 Rockville Pike Rockville MD 20852 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Heroin and cocaine intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine naise Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED attending physician or use as the burial ^#EJ9E\_PII,27,28a-f, perME, g864 2/21/07 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Year Fetal death Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by t be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Diabetes mellitus Completed of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene After this ဥ 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Manner of Death Natural Division Pending 1 Yes 2 X No unknown death Director: in by the Fnd 1/27/2007 Fnd 5:45 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 13105 Alpine Dr. Germantown. 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be 3 Suicide determined (Specify) found at residence Germantown. Homicide

Hospital or Attending Physician: To the within 2 To the complet

29a. Certifier 1

Mary G 31. Date filed

29b. Signature and title of certifie

30. Name and address of person

Ripple MD

Medical

State

Registrar

Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

and manner stated

2007

completed cause of death (Item 23a)

10

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d Date signed (Month, Day, Year)

January 28, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 17

		1 = For State Registrar		Cei	rtificate	of Dea	th	Req	. No.		
		Decedent's Name (First, Middle, Last)						2. Date of Death Month			3. Time of Death
Physici /Medic		Eugene Ralph	Friend					January	21,	2007	9:15 A <sup>M</sup>
Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	own, or Local	ion of Death		4c. Cour	nty of Death	
	g).	113 E. Second Ave.					eights		Ga	rrett	
Funeral Director		212-24-1867	7. Age (In yrs. In 77	ast birthday) Yrs.	If Under 1 Months [	Year If Ur Days Hou	irs Min.	8. Date of Birth (Month, Day, Y	<sup>ear)</sup> 1930	Cou	place (State or Foreign ntry) 1and
and and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation	·	· · · · · · · · · · · · · · · · · · ·			1	Od, Inside City Limits
faho	ō	MD Garret			nn Hei	ich+c					1∭XYes 2☐No
2 Should be lined within 7.2 hours after death with the maryland and Mental Hyglene. Is marked other than "natural", or itama 23a or 28e-f show sumatic avant, the Madical Examinat must be notified at	rect	10e. Street and Number	1.3	och Ly	10f. Zip C			100	. Citizen o	of What Cou	ntry?
3a or	0	113 E. Second Ave.				215	50			SA	,.
ma 2	Funeral Director		2. Was Decedent Ever in U.	S. 13.	Was Deceder			ecify Yes or No- Rican, etc.)	14. R	ace - Amend	
er se	F	1 ☐ Never Married 2X Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		r ves, speciry 1 □ Yes 2 🛭			Hican, etc.)		lack, White,	
- 3	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: Kore	а	1 Tes 22	NO Spe	Cily.		Spec	city: Whi	te
dica	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual ( kind of work of DO NOT use	done durina	most of work	ng 16	b. Kind of	Business/In	dustry
than than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			,	echani	CI	uroh	/ 1+	Repair
Hygle ther ant.		17. Father's Name (First, Middle, Last)		PILITE	stel/ F			(First, Middle, Ma			кератг
ked c	To Be	John	Friend				Laura			Upho]	.d
mar mar	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address (S	Street and No	mber or Rura	I Route Number, C	ity or Tow		
27 is 27 is r trai		Janet Y. Friend/ W	ife	113 E	. Seco	ond Av	e., Lo	ch Lynn F	leigh	ts, MI	21550
itam itam othe		20a. Method of Disposition	CC CC	ace of Dispo	sition (Name natory or othe	of	_			n - City or To	
int: If		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cemete		1/24	/07 0	akla	nd, Ma	ryland
Department of Health and Mental Hygiene. Important: or itama 23s or 28e-f show Important: If itam 27 is marked other than "natural; or itama 23s or 28e-f show any injury or other traumatic avant, the Madical Examinat must be notified at once.		21. Signature of Funeral Service Process			2. Name and		•			ond St	
		23a. Part1. Enter the disease, or compli	cations that caused the death	,				me Oakla		MD 21	.550 Approximate
hysician		Immediate Cause (Final	e cause on each line.								Interval Between Onset and Death
Medical		disease or condition resulting in death)	Ischemic Ca		yopath	ıy				У	ears
xaminer			Coronary A		Dicase					37	oare
	Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		DISCUS					l y	ears
ransii	Examiner	Cause (Disease or injury that initiated events	High Blood	Press	ure					у	ears
ien ar urial-t		resulting in death) Last	Due to (or as a consequ	ience of):							
ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Medical										
attending p	Me	IF FEMALE:	110000000000000000000000000000000000000	-							
signed by the attendin I be detached for use	hysician	us the past 12 months?	3c. If yes, outcome of pregnar	death 3	Ectopic preg					Date of delive Month	Day Year
the ched	yslc	1 Yes 2 No WA	4 ☐ Pregnant at time of de 9 ☐ Unknown	atn 5L	Other (spec	:ny)					
ed by deta	0	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlying cau	ise given in F	art I.	23e. Did toba	cco use co	ontribute to the	ne cause of death?
sign le	d by							1 ☐ Yes	2 <b>X</b> No	3 Prot	oably 4 Unknow
s peen si	Completed			-		<del></del>		24a. Was an	241	h Were auto	psy lindings availab
e has	шc							autopsy		prior to co death?	mpletion of cause of
tificat or, pa	Ö	25. Was case referred to medical				26.5	Place of Dogst	1 Yes 2 Check only one	No	1 🗆 Yes	2□ No
s cert direct	0.0	examiner?	ospital:	ER/Outpatier	nt 3 DOA	7		me 5 X Residence	а 6 ПC	ther (Specif	vl
er th	i i	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		: Injury at Work?		28d. Describe how			7/
ath. or: Afr ne fur	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monin, Day rear)	пцигу	м	1 Tes	2 □ No				
Directo in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, str	eet, lactory, o	office		281. Location (Stree City or Town,		mber or Rura	I Route Number,
within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phys	icien: To the best of my know	wledge, deat	h occurred at	the time, dai	e and place,	and due to the cau	se(s) and	manner as s	tated.
tha F	Medical	Une)	er: On the basis of examinat and manner stated.	iori alluvoi (N							
	Σ	29b. Signature and title of dertifier	/		29c. l	License num		29d	_	ned (Month,	Day, Year)
IVA						D1533	3		1/2	2/07	
1 4		30. Name and address of person who co				0			0155	0	
		Dr. Thomas Johnson 31. Date liled (Month, Day, Year)	32. Hegistrar's Signat		h St.,	, Oakl	and, M	aryland	2155	U	
Sta Registi		IAN 2 5 20	07 Seguistrar's Signal	H A	make !						

	•	1 - For State Registrar	State of M	aryland			of Death		Reg. No	2007	0303
Physicia /Medic		Decedent's Name (First, Middle, Last	Max Max		GEL	FAND		2. Date of Month	Da ry 18	2007	1:35 P
Examin	er	4a. Facility Name (If not institution, given Hebrew Home of Gr	eater Was	hingt		4b. City, Tow Rocky:			1	. County of De	
Funeral Director		102-10-0707	M 2□F	90	ast birthday) Yrs.			Min. (Month,	Day, Year,		Country)
Aaryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomi	co	-	, Town or Lo	cation					10d. Inside City Lin 1 ☐ Yes 2 ☐
with the radio of	Director	10e. Street and Number 9259. Tournament D				10f. Zip Co.				Citizen of What Country?  Lted States	
n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show Alcal Exentinal must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 7 Yes 2 1 If Yes, Give Year or Dates:	? .   No		Was Decedent f Yes, specify	Cuban, Mexican, P	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ai Black, W Specify: W	
within 72 ane. then "na	Completed	15. Decedent's E. (Specify only highest gra	ducation		16a. Deced (Give life. L	dent's Usual O kind of work d DO NOT use re	one during most of	ne during most of working			
	To Be Co	17. Father's Name (First, Middle, Last, Isaac Gelfand	)					Name (First, Midde Cca Rosof		n Sumame)	
and em		19a. Informant's Name/Relationship ( Elissa Ritzenberg		r				or Rural Route Nur			
of of Health t: if itsm 27 i		20a. Method of Disposition  **Burial 2 Cremation 3	Removal from State	20b. P	lace of Dispo emetery, crer	sition (Name on matory or other	of place) 0]	/21/07	20c. L	ocation - City	or Town, State
Department of the first it its any injury or of once.		21. Sig at Leseral Service Licer  23a. Part Enter the disease, or com	nsee	_	To	name and A		v Funeral	Home	2	ch. VA
ate has been signed by the attending physicien and has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumon Due to (or a b. Due to (or a c. Due to (or a	s a consequ	uence of):						Onset and Dea 1 Week
ted by the attending phy detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3[	⊒Ectopic pregr ⊒ Other ( <i>speci</i> i			-	23d. Date of Month	delivery Day Yea
signed by	2	Part II. Other significant conditions	contributing to death	but not resi	ulting in the u	inderlying caus	e given in Part I.				e to the cause of deat
	Completed							24a. W au pe 1 🗆 Ye	utopsy erformed?	prior death	autopsy findings ava to completion of caus 1? fes 2 \( \text{No} \)
r this certificate har all director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1  Inpa	tient 2 🗆	ER/Outpatier	nt 3 DOA		f Death   Check on ing Home 5 R		6 □Other (S	Specify)
r death. ector: After this by the funeral di	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		jury Day Year)	28b. Time o Injury	of 28c.	Injury at Work? 1 Yes 2 No	28d. Descri		ury occurred	
To the nospite or Auenainy Firsy within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not to determined	building,	etc. (Specif	y)			City or	Town, Sta	(e)	r Rural Route Number
Fune Fune	Medical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, deat tion and/or in	th occurred at to evestigation, in	he time, date and my opinion, death	place, and due to to occurred at the tin	the cause( ne, date ar	s) and manner nd place, and	r as stated. due to the cause(s)
0 0				-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:45 P M John Russell Glaze January 18 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 216-22-1751 85 Director 18, 1921 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25315 Burnt Hill Road 20871 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Farmer/Musician Farming/Music permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Basil Russell Bertie May King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance B. Glaze - Wife 25315 Burnt Hill Road, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Clarksburg Meth. Cemetery 1/23/07 Clarksburg, Maryland 4 Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 126401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 days Physician Anoric enceptaliputhy disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Dradycardic Arrest Sequentially list conditions, the same sequence of the same sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit CArcinima and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year signed by the at the detached for 4□Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed HT certificate I untens ico 1 Yes 2 No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၀ 1 Dinpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 🗗 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death. To the Funeral Director: / completely filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 4 4 8 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West Ninth Street, Martha Pierce M.D. Frederick, Maryland 31. Date filed (Month, Day, Year) egistrar's Signatur State 2007 Registrar

		1 - For State Registrar	State of		artment of Health rtificate of Deati		lygiene Reg. No:	7 03033
D1		1. Decedent's Name (First, Middle				2. Date of Month	Death	3. Time of Death
Physic /Med		Thayne Cope Gr	een			Janua	ry 23, 20	007 10:54 P.M
Exam		4a. Facility Name (If not institution, Garrett County	•		4b. City, Town, or Location Oakland	n of Death	4c. County Ga1	of Death
Funera Directo		5. Social Security Number 513–10–3788	6. Sex 7. 11∕2 M 2 □ F	Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year If Under Months Days Hours	er 24 Hrs. 8. Date of (Month) Mar 2	Birth (Pay, Year)	Birthplace (State or Foreign Country)     Kansas
pu .		Usual Residence of Decedent  10a. State 10b. County		10-0-				
the Marylend r 28a-f ahow notified at	7	The state of the s		10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
the N	ecto	MD Garre  10e. Street and Number	CC	Accident	· · · · · · · · · · · · · · · · · · ·		1.0.00	
章 克爾	Funeral Director	1073 Aiken-Mil	ler Road		10f. Zip Code 21520		10g. Citizen of V	Nhat Country?
deeth w	era	11. Marital Status	12 Was Deced	ent Ever in U.S. 13.		rigin? (Specify Ves or		e - American Indian,
or Ita	<b>6</b>	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forc	es? WW 2, □No Korea,	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2√ No Specif		Specify	ck, White, etc.
72 hours natural',	Completed	15. Decedent		Vietnam 16a. Dece	dent's Usual Occupation		16b. Kind of Bu	usiness/Industry
the of	el dr	(Specify only highes Elementary/Secondary (0-12)	College (1-4	lor 5+)	kind of work done during mo DO NOT use retired)	ost of working		
T	S		5+ year	s Majo	r, Retired		U.S. Ai	ir Force
be fited Hy doth	Be	17. Father's Name (First, Middle, I	Last)			her's Name (First, Mid	dle, <b>M</b> aiden Surnam	ne)
2 should be and Mentel Is marked sumatic av	P	Raymond Green		.,		Hazel Cope		
d 2 should be filed th and Mentel Hyg ?7 is marked othe traumatic avant,		19a. Informant's Name/Relationsh			ng Address (Street and Num.			
s 1 end 2 if Heelth a litam 27 to other tra		Ethel E. Green	/wire	20b. Place of Dispo	Aiken-Miller	Date		21520
permit. Pages 1 end Department of Heelt Important: If Itam 2 any Injury or other once.		1 Burial 2 Coremation  4 Donation 5 Other (Sp.		cemetery, cree	natory or other place) Side Crem. Jan			City or Town, State
Depart Import any In		21. Signature of Funeral Service L	um and	N	2. Name and Address of Fac lewman Funeral	l Homes, P.		
Physician /Medical		23a. Part1. Enter the disease or shock, or healt failure. List of immediate Cause (Final disease or condition resulting in death)	a Athe	roscleroti	er the mode of dying, such a			Approximate Interval Between Onset and Death YTS
cate be executed by physicien end minimum in the buriel-trensit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <u>Cere</u> Due to (or	as a consequence of):  brovascula as a consequence of):  as a consequence of):	r disease			4 yrs
thet the death certifi ed by the attending deteched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Fetal death 3 tat time of death 5	Ectopic pregnancy Other (specify)		23d. Dat	e of delivery nth Day Year
w requires the been signed I should be det	ed by P	Part If. Other significant condition Hypertensio		th but not resulting in the u	nderlying cause given in Part	1		ribute to the cause of death?  3 Probably 4 Unknown
- 5 %	plet	Hx of prost	ate canc	er		24a. W	as an 24b. V	Vere autopsy findings available
: The lew cete has t	Completed					—— au pe 1 ☐ Yes	rformed?	prior to completion of cause of leath? ☐ Yes 2☐ No
ician: Th cartificete rector, peg	Be	25. Was case referred to medical examiner?	Henrital.			e of Death (Check on	y one)	
Phys this el dii	2	1 ☐ Yes 2√2 No 27. Manner of Death	Hospital:			lursing Home 5 Re		
After After	lo	1 X Natural 5 ☐ Pending		Injury 28b. Time of Injury	Work?		e how injury occurr	ed
or Attar after dea Diractor in by the	Certification;	2 Accident investigi 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place of	Injury - At home, farm, str , etc. (Specify)		28f. Location	(Street and Number Town, State)	er or Rural Route Number,
A Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier 1 Certifying (Check only one) Medical E	g Physician: To the be examiner: On the basi and manner	s of examination and/or in-	n occurred at the time, date a vestigation, in my opinion, de	and place, and due to the time at the time.	ne cause(s) and ma e, date and place, a	nner as stated. and due to the cause(s)
To the within 2 To the comple	₩ E	29b. Signature/and title of certifier)	1	′ ~	29c. License number		29d. Date signed	(Month, Day, Year)
F > F 0		> / Java Va	& thate	En co	D30035		01-24-	
		30. Name and address of person v	who completed cause	of death (Item 23a) (Type	Print)			
		Donald R. Ri				ive Oakla	nd, MD	21550
St	ate	31. Date filed (Month, Day, Year)		istrar's Signature				
Regis		JAN 2 (	2007	allega A B	want o			

			For State Registrar	State of	Marylan		rtment of tificate	Health and M If Death		ene 2007	03034
			Decedent's Name (First, Middle, Last	)					2. Date of Death	Day Year	3. Time of Death
	Physicia		James Thurl	Gowe	er, II				Month January	23, 2007	2:15 P M
	/Medic		4a. Facility Name (If not institution, give				4b. City, Town	n, or Location of Death		4c. County of Death	1
	Examin	er	Garrett County Me			a1	Oak	land		Garret	t
	Euparal		Social Security Number 6. S		. Age (In yrs. I		If Under 1 Ye		8. Date of Birth	9. Birth	oplace (State or Foreign
	Funeral Director		220-10-0756	ØM 2□F	85	Yrs.	Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Y Sept. 25	, 1921 M	aryland
			Usual Residence of Decedent								404 Inside Challimite
	ylan how		10a. State 10b. County		10c. City	, Town or Lo		. 1			10d. Inside City Limits 1 ☐ Yes 2X No
	a Ma	cto	MD Garr	ett			Oaklar	ıa			
	or 28	Director	10e. Street and Number				10f. Zip Cod		100	. Citizen of What Co	untry?
	be lied within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other then "natural", or items 23a or 28a-f show event, it a Manical Examinar must be inclined at		2362 Broadford R	oad				21550		USA	
	ems	Funeral	11, Marital Status	12. Was Deced Armed Ford	es?	S. 13. \	Vas Decedent Yes, specify (	of Hispanic Origin? (Sp. Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
٥	afte or it		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give			☐ Yes 2【】	No Specify:		Specify:	White
3	ural',	d by	3 Widowed 4 Divorced	Year or Dat	tes:	100 Danie	tente Hevel Or	averties.	16	6b. Kind of Business/	
Ÿ	"nat	Completed	15. Decedent's Ed (Specify only highest gra			(Give	lent's Usual Oc kind of work do OO NOT use re	ne during most of work tired)	ing	b. King of Basillosa	industry .
7	then the	E G	Elementary/Secondary (0-12)	College (1-	4or 5+)		Farmer	,		Farming	
N	Hygie Ther nt.		17. Father's Name (First, Middle, Last)		-	l		18. Mother's Name	e (First, Middle, Ma	iden Surname)	
<u> </u>	ed o ed o	Be C	James Thurl	Gowe	er, I			Malva	Jane	Bowser	
2	houk d Me mark matic	၉	19a. Informant's Name/Relationship (7	vpe. Print)		19b. Mailir	ng Address (Str	eet and Number or Run	al Route Number, (	City or Town, State, 2	Zip Code)
Σ Σ	d 2 s th an 17 is trau		I. Virginia Gowe				-	ord Road, 0			21550
o,	1 an Heal em 2 em 2		20a. Method of Disposition		20b. F		sition (Name o			c. Location - City or	Town, State
בַ	ages nt of :: # It		1 X Burial 2 ☐ Cremation 3 ☐				natory or otner e Cemet		7/07	Oakland, I	Maryland
Baltimore, Maryland 21215-0036	it. P. Intenti Injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funefal Service Ligen</li> </ul>		1			Idress of Facility		Second S	
Ra	permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Importent: if I lem 27 is marked oth any injury or other traumatic event <u>once.</u>		De Signal	TO CO	λ			Funeral Hom			1550
			23a. Part1. Enter the disease, or comp	lications that ca	used the deat					, ,	Approximate
			shock, or heart failure. List only	one cause on ea	ich line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a			cciden				Hours
	Examiner			,	or as a conseq		nsuffi	ciency			Years
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a conseq		.HSULLA	cachey			
	ted nsit	Examiner	Cause (Disease or injury	High	Blood	Pressu	ire				Years
_	xecu and al-tra	xai	that initiated events resulting in death) Last	C	or as a conseq						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicalE		đ							
687	icate phys s the	윷		. u.							
×	certii nding Ise a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			<b>7</b>			23d. Date of de	ivery
Вох	atter for	ciai	in the past 12 months?	4∐Pregna	nth 2 ∏ Feta ant at time of d		∃Ectopic pregn ∃ Other <i>(specif</i> )			Month	Day Year
<u>Ф</u> О	the c y the achec	ysi	9 Unknown	9□ Unkno	wn						
σ.	wrequires that the death certific been signed by the attending f should be detached for use as	by Physician/Med	Part II. Other significant conditions of				nderlying caus	e given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
g	quires n sign		Diabetes Me	llitus	Type I	[			1 🗆 Yes	2 1 No 3 □ Pr	robably 4 Unknown
20	w rec	Completed	High Choles	terol					24a. Was an	24b. Were at	utopsy findings available completion of cause of
æ	he ta e has age 2	E							autopsy perform	ed? death?	2 No
ā	ifficat or, pa	Ö	25. Was case referred to medical					26. Place of Dea	th Check onl. one		
>	/sicia s cert	To B	examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	Other: 4 Nursing He	ome 5 Resider	ice 6 Other (Spe	cify)
Division of Vital Records,	a Physer this	L.	27. Mann Death	28a. Date o	of Injury h, Day Year)	28b. Time o	f 28c.	Injury at Work?	28d. Describe how	v injury occurred	
<u>o</u>	ading: : Afte	atio	1 Natural 5 Pending 2 Accident investigation		n, Day roury	injury	М	1 ☐ Yes 2 ☐ No			
<u>S</u>	Atter	ifica	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	208. Flace	of Injury - At h	ome, farm, st	reet, factory, of	fice	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
ā	el or s afte sl Dir	Certification:	4	Dundii	.g, 0.0. (apobl				•		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	al (	29a. Certifier 1 Certifying Ph	ysician: To the	best of my kno	owledge, deat	h occurred at to	ne time, date and place, my opinion, death occur	and due to the car	use(s) and manner as	s stated. e to the cause(s)
	n 24 he Fu	edical	(Check only 2 Medical Examone)	and mann	ner stated.	and and of it					
	To the To the Comp	ž	29b. Signature and title of certifier				29c. Li	cense number	29	d. Date signed (Mont	n, Day, Year)
	10		1					117 2 3	5	1/23/	")
			30. Name and address of person who						4	1 1 0	1550
			Dr. Thomas Johns		-		Fourth	Street, Oal	cland, Ma	ryland 2.	1550
	St Regist	ate	31. Date filed (Month, Day, Year)	2007 N	egistrar's Sign	ature	Society)				

07-00716

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Olivia Frances Gadson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Time of Death Month Day January 25, 2007 Medical Examiner 1920 hrs 01ivia Frances 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 6029 Surrey Square Lane District Heights Prince George's 5. Social Security Number 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9. Birthplace (State of **Funeral** oreig Washington Days Director 578-94-5411 43 M 2XF July 22. 1963 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits 1 X Yes 2 fother than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once, Maryland Prince Georges Forestville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6029 Surrey Square Lane 20747 United States Baltimore, MD 21215-0036
ermit. Pages I and 2 should be filed within 72 hours after death with
epartment of Health and Mental Hygiene
upportant: If item 27 is marked other than "natural" or issued other traumatic event. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married White etc. 2 Yes 2 X No Specify: Black Yes 2<sup>X</sup> No specify. Widowed Divorced f Yes. Give Year þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Gadson, Sr Dorothy G. Butler (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print.) 809 Clovis Ave. Capitol Heights, Md. Rosalind S. Best /Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Landover, Md. important: Donation 5 Other Specify: Harmony Memorial Feb.1, 2007 21. Signature of Funeral Servi censee 22. Name and Address of Facility Alexander S. Pope /P.A. 5538 Mariboro Pike/Forestville, Md. 0101605 20747 Physician /Medical Part | Enter the dise se, or complication failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death a Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED physician the burial -AMENDED 11,27, perME, g865, 3/1/07 tT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the use as t Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months Pregnant at time of death Other (Specify 1 Yes 2 No 9 V Unknown 9 Unknown the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. 23e Did tobacco use contribute to the cause of death? ģ Diabetes mellitus 1 Yes 2 No 3 Probably 4 V Unknown Completed peen 24a Was an 24b. Were autopsy findings available has t autoosv prior to completion of cause of performed? page certificate ✓ Yes 2 No No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director. 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 DOA Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes Inpatient 2 ER/Outpatient 3 ဥ 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 26, 2007 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day Year) 32. Registrar's Signaturg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5 Per FH G865 3/07/07 Department of Health and Mental Hygiene Amend #5 Per FH G865 3/07/07 Centificate of Death

Reg. No. Name (First, Middle, Last) 1 - State Registrar/NFND#23I+II.25, Reg. No. 2. Date of Death 3. Time of Death **Physician** Month Year HELLER 200  $I \bigcirc$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater wash. ROCKUILLE MONTGOMER ff Under 1 Year If Under 24 Hrs. 053+05+3533 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🔀 F Hours NEW 220 30 7463 95 YORK Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f show the Medical Examinat must be motified at 10d, fnside City Limits MARYLAND MONTGOMERY 1 ☐ Yes 2 TNo Directo CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4450 S. PARK AVE APT 904 20815 USA 12. Was Decedent Ever in U.S. Armed Forces2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes ≱ No Maryland 21215-0036 þ Specify: Specify: CAUCASIAN 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY U.S CONGRESS marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F NATHAN COHEN SARAH FORCHNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ss 1 and 2 st of Health and item 27 is r ALLAN DONALDSON/NEPHEW 118 JOHNSON DR EXTENSION PLAINFIELD, NJ 07060 Baltimore, 20a. Method of Disposition 20b. Pface of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Depertment of Hi
Important: If iter 1 □ Burial 2 ☐ Cremation 3 □ Removaf from State NATIONAL CREMATORY JAN. 22 2007 FALLS CHURCH, VA \* 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licensee mare 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARLINGTON, VA Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician YEARS** /Medical Examiner tASI+ Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Examiner TEP-PRACTURE certificate be executed as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? (specify) 3 Ectop for Month Day Year 4☐Pregnant at time of death 5 Other P.O. I 1 ☐ Yes 2 No detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š of Vital Records, should be 1 🗌 Yes 2 🗆 No 3 ☐ Probably 4 Munknown Completed been HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? res 2 100 07 ROIDI 1 ☐ Yes Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) ٩ 1X Yes 28 2 ER/Outpatient 3 DOA completely filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation 1 ☐ Yes 2**▼**No 2X Accident Fell at dinner time Sept 27,2006 5:30 pm 6 ☐ Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6105 Montrose Road Rockville, MD 20852 Hebrew Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57784 time Konon, MD Jan 10 2007 POCKULLE, MO 20852 MONTROSE ROAP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KORZAN, 105

State Registrar 31. Date filed (Month, Day, Year) JAN 19 2007

ATUNA

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:20 AM Heptina 76. Albert 07 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville
If Under 1 Year | If Under
Months | Days | Hours | Charlestown Care Center Baltimore 8. Date of Birth 11/3/1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Maryland 216 18 3182 83 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and term 27 is marked other than "natural", or Iteme 23s or 28s-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County treumatic event, the Medical Examiner must be notified at 1 Yes 2 No MD Completed by Funeral Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000-3B Spring Gate Rd. 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 NowXII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Controller Commercial Credit Co. 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Leroy Hepting Sophia Gertrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert A. Hepting, Jr./son 1000-3B Spring Gate Rd. Catonsville, MD 21228 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2007 Ellicott City, MD St. Johns Cemetery 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01442 4112 Old Columbia Pk. Ellicott City, MD 21043 lenoner 1 5,000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preymonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for 1 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ pege 2 should be 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No Division of Vital 1 Tyes : After this certifice s funeral director, r or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deat Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier DY4 377 , mes (ot) 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catinsville, mo 711 maiden Choice Bowlin MD 31. Date filed (Month, Day, Year) 32. Resistrar's Signature 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, 2007 Month January Emma Elizabeth Woodson Kennedy 3:344 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. 1 □ M 2 🖫 F Hours 83 220-98-8333 12/25/1923 Liberia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Prince Georges Mitchellville 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1802 Waesche Court 20721 Liberia 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐No Specify. Black Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delia Cuspod Henry Z. Woodson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Walker/Daughter 1802 Waesche Court Mitchellville,MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Cem. 02-3-2007 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Six ature of uneral Service Licensee 22. Name and Address of Facility Taylor's Funeral Home 1722 N.Capitol St.NW Washington, DC 20002 mal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 OYFARS disease or condition resulting in death) Due to (or as a consequence of). 651 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. if yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITU 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

/Medical Examiner death certificate be executed the burial-trar P.O. Box 68760. use as t atter for ned by the a detached f or Vital Records, signe 1 be c page 2 this

Attending Physician: funeral After death,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

**Funeral** 

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

al Hygiene.

d 2 should be fill h and Mental H r is marked oth

Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other tra

Department Important: If any injury or

Physician

aryland

Baltimore,

72 hours after death with the Maryland

Division ours after death, neral Director: A filled in by the fu 6 within 24 hours a To the Hospital completely

State

Registrar

31. Date filed (Month, Day JAN 22 200

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

PKWY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOVER

32. Registrar's Signat

5-State

DHMH 17 Rev 1/2001

Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 1 9 2007

P21197

22 S. Greene St, baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 14, 2007

and manner stated

, M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Neda Homayonnpour, M.D.,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
AMEND ITEM 20b, per FH, Coo4, 2,207, MS
State of Maryland / Department of Health and Mental Hygiene

		State of Maryland / I	Certificate of De	•	Reg. No. 007 03040
Physician	Decedent's Nama (First, Middle, Last			2. Data of De Month	Day Year 125
/Medical Examiner	Charles Alfre	d Kongro, Jr.  street and number)	4b. C	ity, Town, or Location of Daar	25 2001   PM
uneral	S. Social Sacurity Number 6. Sa	PERSIDE		DelCAMD Indar 24 Hrs. 8 Date of Biours Min. (Month, Da	ARRETORI.
rector	199-22-6575	XM 2□ F 77	Yrs. Months Days He	ours Min. /(Month, Da Dec. 1	4, 1929 Pennsylvania
-	Usual Rasidance of Decedant  10a. Stata 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
edical Examiner must be notified at letted by Funeral Director	MD Harford		chville		1 □ Yas 2 🔀 No
5	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
ai O	212 Hopewell Road		21028		U.S.A.
y Funeral Director	1 ☐ Navar Marriad 2 ☐ Married	12. Was Dacedant Evar in U,S. Armad Forcas? 1 ∑Yas 2 ☐ No If Yas, Giva 1 0 4 7 7 4		nic Origin? (Specify Yas or No exican, Puarto Rican, etc.) ecify:	C==='4"
Q Pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Yaar or Datas 1947-74	Decedent's Usual Occupation		16b. Kind of Businass/Industry
Be Completed by	(Spacify only highest grad	Collega (1-40F5+)	. Decedent's Usual Occupetion (Give kind of work done during lifa. DO NOT usa retired) litary	g most of working	U.S. Government
To Be C	17. Fathar's Nama (First, Middla, Last) Charles A. Kong		18.	Mothar's Nama (First, Middla Helen M. Lang	
-	19a. Informant's Name/Ralationship (T)	rpe, Print) 19t	o. Mailing Address (Straat and I	Number or Rural Routa Numb	ear, City or Town, State, Zip Code)
	Sieglinde Hinton		8 Lewis Drive	Aberdeen,	
	20a. Method of Disposition 1	Removal from State  20b. Place of comete Arling	f Disposition (Name of ry, crematory or other place) ton National C	emet, 2/21/2007	20c. Location - City or Town, Stata  Arlington, Virginia
once. To Be Comp	21. Signatura of Funaral Sarvice Licens	өа .	22. Nama and Addrass of	Facility argo Funeral	Horas D. A.
ol	Kirstnithiu	plinglespe	Aberdeen,	Maryland 21	001–3399
je.	23a. Part1. Enter the disease, or com- shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Advanced	consaquance of):	hall Cell Lung	Approximata Intarval Balwaen Onsat and Daath
edical Examiner	Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Ceusa (Diseasa or injury that initiated avants rasulting in death) Last	>	consequance of):		
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y Physi	Part II. Other significant conditions cor	ntributing to daath but not resulting i	n the underlying causa givan in		tobacco usa contributa to tha causa of death Yes 2☑No 3□ Probably 4□ Unknow
Completed by Physician/N				24a. Was	an autopsy primed? 24b. Wera autopsy findings available prior to complation of causa of death?
Co				1□	Yas 2□No 1□Yas 2□No
o Be	25. Was casa referred to medical axaminar?  1 \( \text{Yas} \) 2 \( \text{Vo} \)	lospital: 1 ☐ Inpatiant 2 ☐ ER/Ou	Other	Place of Death (Chack only	
n: To Be Com	27. Manner of Daath	28a. Date of Injury 28b.	Tima of 28c. Injury at	Varsing Home 5 ☐ Rasi 28d. Dascriba	dence 6 ⊟Other (Specify) how injury occurred
Medical Certification:	1 Natural 5 Pending 2 Accidant invastigation 3 Suicide 4 Homicide Getermined	28a. Place of Injury - At home, fa building, etc. (Specify)	M 1 ☐ Yes	28f. Location (	Straat and Numbar or Rural Route Number, wn, Stata)
ai Cei	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge	e, death occurred at the time de	ate and plece, and due to the	causa(s) and manner as stated
X ICE	(Check only one)	ner: On the best of my knowledge and mannar stated.	d/or invastigation, in my opinior	n, death occurred at the time,	date and place, and due to the cause(s)
M	29b. Signatura and title of certifier	KM() -10	29c. License nun	nber	29d. Date signad (Month, Day, Year)
1	30. Nama and eddress of person who co	mplated cadse of death (Item 23e)	(Type, Print)	treat 1	anuary 25, 2007
State	31. Dete filed (Month, Day, Year)	2. Registrar's Signatura	1	11-01	X1001
istrar	FFB 0 2 2007	Manney 18 A	Marke 3	<i></i>	/- 10011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** 8:00 PM JANUARY 19, 2007 ANNA LANGOHR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GRASONVILLE QUEEN ANNE'S 110 BAYVIEW If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F Yrs. 95 JUNE 22, 1911 MARYLAND Director 212-28-6367 Usual Residence of Decedent e filed within 72 hours after death with the Maryland if Hygiene.
If Hygiene.
Anders then "naturel", or Iteme 23a or 28a-1 ahow went, the Medical Examinar must be notified at went, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Directo MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 1328 QUEEN ANNE'S DRIVE USA 21619 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL CAFETERIA COOK . Pages 1 and 2 should be filed vitnent of Health and Mental Hygie 1 ant: If Itam 27 is marked other flury or other traumatic avent, It 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ၉ JOSEPH STIPEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 BAYVIEW, GRASONVILLE, MARYLAND 21638 JUNE PRINGLE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State JANUARY 24, permit. Page Depertment of Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) 2007 EASTON, MARYLAND WOODLAWN MEMORIAL CEMETERY 22. Name and Address of Facility
FELLOWS, HELFEN 21. Signature of Funeral Service Licenses HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A. C 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final arter discess COLUNALS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ № 24a. Was an page 2 s autopsy certificete 1 Yes 2 N or Attanding Physician: After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Naturat 5 Pending 1 Tes 2 No 2 Accident investigation actor: / the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t within 24 hours effer of To the Funerei Dirac completely fitted in by 4 - Homicide 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical /2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juste Zui Ma CI 7 31. Date filed (Month) 2 2007 32. Floistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:43 PM Lins 01 07 Devaid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore If Under 1 Year | If Under 24 Hrs. University of Maryland Medical 5. Social Security Number 6. Sex Systems 8. Date of Birth (Month, Day, Year) JULY 17,1939 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Min. 1 MM 2 □ F MARYLAND 67 213-38-9580 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 □ No Director QUEEN ANNE CENTREVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21617 110 WATSON ROAD Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1958—1964 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALON & SPA SALESMAN 12 -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH NASH ELMER LINS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 307 CHESTERFIELD AVENUE, CENTREVILLE, MD 21617 JEREMY A. LINS/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION JAN. 22, 2007 STEVENSVILLE, MD 21666 CENTER LLC Fineral Service Licensee 21. Signatur FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** acute muscardial infarction /Medical Due to (or as a consequence of): Examiner ampullaru adano carcinoma if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-trar Due to (or as a consequence of) physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2 2 2007

MD

29d. Date signed (Month, Day, Year) 29c. License number

01/19/07

AU4176435521678 30. Name and address of person ocompleted cause of eath (Item 23a) (Type, Print)

and manner stated.

South Greene

32. Registrar's Signature

Street, Baltimore, Mo 21201

State Registrar

filled in by

		4	State of Maryla		artment of H			0.00	7 0001.3
			Registrar	Cei	tilicate of L	Jeani	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last)				Month	Day Yea	r
	/Medic	al	Charlotte I. Lipps		4b. City. Town, or	Location of Death	January	17 2007 4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give street and number)					,	
_			Northampton Manor  5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	erick   If Under 24 Hrs.	8. Date of Birth (Month, Day	Frede	ETICK Birthplace (State or Foreign
	Funeral		1 □ M 2 💢 F	94 Yrs.	Months Days	Hours Min.	Sept. 1	7, Year) 2, 1912 Ma	Country) aryland
1	Director	-	220-78-5511 Usual Residence of Decedent	/			Dept	_, _,	
	/land ow at		10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Man Fish fied	to	Maryland Frederick	Frede	rick				1 X Yes 2 No
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	h witl 3a o st be	<u>a</u>	206 East 6th Street		21701			United S	tates
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Al Black, W	merican Indian, hite, etc.
0	after or ite mîne		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
3	ral",	d by	3 XWidowed 4 ☐ Divorced Year or Dates:					40h Kind of Busins	and the description of
ה ה	72 h natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Busine	ss/industry
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7	led w lygier her th		12 17. Father's Name (First, Middle, Last)	110	memaker	18. Mother's Nar	ne (First. Middle.	Maiden Surname)	Home
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<u>Ya</u>	ould Mer narke	유	Milton Ezra Frit		ng Address (Street	Mary		er, City or Town, State	
Mag	2 sh and rs rr		19a. Informant's Name/Relationship (Type. Print)						
മ ബ്	land dealth		Mary Crabbs / Daughter  20a. Method of Disposition 20		Last oth	St./ Fre	Date Date	Maryland 20c. Location - City	
Ö	ges tof H		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	matory or other plac		0./0007		
aitimo	. Ра tmen tant: jury				ivet Cem.		2/2007	Frederick	
a a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mertal Hyldene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee					Funeral Ho ederick, M	
_			23a. Part1. Exper the disease, or complications that caused the disease.						Approximate
			shock, of heart failure. List only one cause on each line.					nest,	Interval Between Onset and Death
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7	/Medical Examiner		resulting in death)  Due to (or as a cor	sequence of):					
	Exammer		Sequentially list conditions, b.	namen of					
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence on					
	ecute and trans	cam	that initiated events resulting in death) Last  Due to (or as a cor	sequence of):					
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_ o	at the de by the a tached f	/sic	1 Yes 2 No 9 Unknown	or death 5					
<u>Р</u>	hat the		Part II. Other significant conditions contributing to death but no	t resulting in the	underlying cause giv	ren in Part I.	23e. Did 1	tobacco use contribut	e to the cause of death?
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Records,	w require been sig	Completed					24a. Was	an 24h Wor	e autopsy findings available
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<u></u>	ding Physician: The lav n. After this certificate has funeral director, page 2	Ö					1□ Yes	2 <b>Y</b> No 1 □	Yes 2□No
Vita	ician sertifi ector	Be	25. Was case referred to medical examiner?		Oth	nor.	ath (Check only		
2	physic this call dire	은	1 Yes 2 PNO 1 Inpatient	2 ER/Outpatie	SIR OLI BOX	4 E Nuising		how injury occurred	Specify)
Z C	ing F After uner	- E	1 ☐Natural 5 ☐ Pending (Month, Day Yea		Wo	rk? ]Yes 2∐No	200. 20001120	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
<u>S</u>	tend leath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be datermined 28e. Place of injury.	At home farm s			28f. Location (	Street and Number of	r Rural Route Number,
Division or	or Al	Certification:	4 Homicide determined building, etc. (S	pecify)	incon, ractory, omeo		City or To	wn, State)	
	urs a		29a, Certifier 1 Certifying Physician: To the best of m	knowledge, dea	ath occurred at the ti	ime, date and plac	e, and due to the	e cause(s) and manne	er as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one)    Check only one   Check one   Check only one   Check on	mination and/or	investigation, in my	opinion, death oc	curred at the time	, date and place, and	due to the cause(s)
	To the within ?	Mec	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (N	fonth, Day, Year)
	F × F 8		//////	MA	. 102	6499		1-1	8-07
	) (		30. Name and address of person who completed cause of death	(Item 23a) /Tvo	Print)				
	4		Ronald E. Miller / 4 Culw			irv. MD	21771		
	Ç.	ate	Od Date Stad (Month Day Your) 32 Religitrarie	Signature		,			····
	Regist		JAN 1 9 2007 Serve	, K	posete				
					<i>a</i>				

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Specke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Cecil Eugene Lewis January 18 2007 12:48A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 488 Hopewell Road Rising Sun Cecil Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1XM 2□ F Hours Yrs. Feb. 27, 1937 Director 69 217-36-4181 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "neturel", or items 23e or 28a-f ehow It e Madical Exeminer must be notified at 1 ☐ Yes 2X No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 488 Hopewell Road 21911 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Millwright Plastics 17 is marked othe treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Susie Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Item 27 Cathleen Lewis/Wife 488 Hopewell Road, Rising Sun, Maryland 21911 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State Department of important: If eny injury or soce. Brookview Cemetery 01-23-2007 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, Maryland 21911 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Onset and Death Immediate Cause (Final disease or condition resulting in death) adenocacinoma **Physician** 6 mo /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has birector, page 2 sl 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Miller a

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State

Registrar

30. Name and address of person who con

9

31. Date filed (Month, Day, Year)

High ST Suite 214 Elklon Modigal

pleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

Physic /Medi	an	Decedent's Name (First, Middle, Last)				2. Date of D	eath Day Year	3. Time of Death
		Lucile Miles				Januai		i al
Exami	ner	4a. Fecility Neme (If not institution, give street and num	ber)		Town, or Location of De	ath	4c. County of De	
		Independence Court	Ago (la vre last hirthday)	Hyat If Under	tsville 1 Year   ff Under 24 F	Irs   P. Data of B	Prince (	
Funeral Director		100 20 0122 1DM 2MF	r. Age (In yrs. last birthday) 9 <b>7</b>			in. Septer	ay Year)	irthplace (State or Forei Country)
		Usual Residence of Decedent	<i>31</i>			pepter	mberzi, Ma	ry1and
how		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limi
	cto	Md Prince George	Hyattsvi	TTE				1 ŽYes 2 □ N
0r 2l	Director	10e. Street and Number	-	10f. Zip			10g. Citizen of What C	Country?
rthan "natural", or Itema 23e or 28e-f ehow the Medical Examinar must be notified at	rai	821 Queens Chapel Roa		207			USA	
E a	Funerai	Armed Ford	tent Ever in U.S. 13. Vices?	Was Decede f Yes, speci	ent of Hispanic Origin? ify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Race - Arr Black, Wh	
5 1	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2  3 ☐ Widowed 4 ☐ Divorced Year or Dat	1	1 ☐ Yes 2	No Specify:		Specify: B	lack
S IS	ted	15. Decedent's Education	16a, Deced	ient's Usuat	f Occupation		16b. Kind of Busines	s/Industry
E BE	pie	(Specify onfy highest grade completed)  Elementary/Secondary (0-12) College (1-	(Give	kind of work DO NOT use	k done during most of v e retired)	vorking	US Govt	
3	Completed	12th	Super	viso	r		US Treas	ıry
event, 1	Be (	17. Father's Name (First, Middle, Last)			18. Mother's N		, Maiden Surname)	
arke atic e	2	Mark Dowdell			Emma	Echols		
Item 27 te marke other traumatic	1 5	19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State,	
m 27 her tr		Johnnie C Parham(Daug				and the state of t		
or of		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Si	20b. Place of Dispos cemetery, crem	sition (Nami natory or oth		Date	20c. Location - City o	
dury	1 3	4 □Donation 5 □ Other (Specify)	Lincoln		1	-20-07	Suitland	Maryland
Important: If I eny injury or once.		21. Signature of Funeral Service cense			J. Young	719 K	anhingter:	DEL 20011
physician and edical miner transit sthe purlaturansit	dical Examiner	resulting in death)  Oue to (o  Sequentially fist conditions, if any leading to impossible cause. Enter Underlying Cause (Disease or injury that initiated events  C	r as a consequence of):  r as a consequence of):  r as a consequence of):	)isea	se			
ittending or use as	Physician/Medical	in the past 12 months?	nt at time of death 5 🗌	Ectopic pred Other (spe			23d. Date of de Month	ofivery Day Year
	by Ph	Part II. Other significant conditions contributing to dea	th but not resulting in the un	iderlying car	use given in Part I.	23e. Did t	obacco use contribute t	o the cause of death?
ned by e detad	D D	Hypertension				1 🗇	Yes 2□No 3□P	robabiy 4 ⊠Unknov
n signed by uld be detac						24a. Was	an 24h Were a	utopsy findings availab
been sigr should be	olete					auto	psy prior to death?	completion of cause o
as been sign 2 should be	Completed					1 Tes	2,2,140	s 2□No
as been sign 2 should be	Be	25. Was case referred to medical examiner?			0.4	eath Check only	one	
is certificate has been sign director, page 2 should be	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospitaf: 1 ☐ Inp			Other: 4 Nursing	eath <i>Check only</i> of Home 5 Resident	one dence 6 □Other (Spe	
is certificate has been sign director, page 2 should be	To Be	examiner?  1  Yes 2 No Hospitaf: 1 Inn  27. Manner of Death 1 Naturaf 5 Pending (Month,		28	Other: 4 Nursing	eath <i>Check only</i> of Home 5 Resident	one	
is cernicate nas been sign director, page 2 should be	To Be	examiner?  1		M 28	Other: 4 Nursing c. Injury at Work? 1 Yes 2 No	Home 5 Resi	one dence 6 □Other (Spechow injury occurred	ecify)
is cernicate nas been sign director, page 2 should be	Certification; To Be	examiner?  1  Yes 2 No  1  Naturer of Death  1  Naturar of Month,  2  Accident of Could not be determined  28e. Place of building  29a. Certiflier  1  Certifying Physician: To the benefit of the benefi	Injury Day Year)  28b. Time of Injury  1 Injury - At home, farm, stre  1, etc. (Specify)  est of my knowledge, death	M 28	A Other: 4 Nursing c. Injury at Work? 1 Yes 2 No office	eath (Check only of Home 5  Residue)  28d. Describe  28f. Location (: City or To:	one]  dence 6 □Other (Specific Notion injury occurred)  Street and Number or Review, State)	ural Route Number,
is certificate has been sign director, page 2 should be	edical Certification; To Be	examiner?  1  Yes 2 No  27. Manner of Death 1  Naturaf 2  Accident 3  Suicide 4  Homicide  29a. Certifier (Check only one)  1  Crtifying Physician: To the bas and manne	Injury Day Year)  28b. Time of Injury Injury - At home, farm, stre I, etc. (Specify)  est of my knowledge, death is of examination and/or invi	M 28i	A Other 4 Nursing ic. Injury at Work? 1 Yes 2 No office  It the time, date and pla in my opinion, death oc	eath (Check only of Home 5  Residue)  28d. Describe  28f. Location (: City or To:	one]  dence 6 □Other (Specific Notion injury occurred)  Street and Number or Review, State)	ural Route Number,
is certificate has been sign director, page 2 should be	Certification; To Be	examiner?  1  Yes 2 No  27. Manner of Death 1  Naturaf 2  Accident 3  Suicide 4  Homicide  29a. Certifier (Check only)  Hospitaf: 1  In Ing (Month.) 28a. Date of (Month.) 28b. Place of building  28b. Place of building	Injury Day Year)  28b. Time of Injury  Injury - At home, farm, stre  est of my knowledge, death is of examination and/or inver r stated.	M 28 occurred at estigation, in 29c.	A Other 4 Nursing ic. Injury at Work? 1 Yes 2 No office t the time, date and plan my opinion, death oc	eath (Check only of Home 5  Residue)  28d. Describe  28f. Location (: City or To:	one]  dence 6 □Other (Specific Notion injury occurred)  Street and Number or Review, State)	ural Route Number, s stated. e to the cause(s)
To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to	edical Certification; To Be	examiner?  1  Yes 2 No  27. Manner of Death 1  Naturaf 2  Accident 3  Suicide 4  Homicide  29a. Certifier (Check only one)  1  Crtifying Physician: To the bas and manne	Injury Day Year)  28b. Time of Injury Injury - At home, farm, stre I, etc. (Specify)  est of my knowledge, death is of examination and/or invi	M 28 occurred at estigation, in 29c.	A Other 4 Nursing ic. Injury at Work? 1 Yes 2 No office  It the time, date and pla in my opinion, death oc	eath / Check only of Home 5 Resi 28d. Describe 28f. Location (: City or Toi ce, and due to the curred at the time,	dence 6 Other (Spenhow injury occurred  Street and Number or R  wn, State)  cause(s) and manner a date and place, and during	ural Route Number, s stated. e to the cause(s)

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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michalski **Physician** Month MATTHEW Joseph 11:00 AN /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Deeth 426 N. Church Street, Apt. 2B Thurmont Frederick Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs. 6 Sav 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) June 2, 1939 **Funeral** Days 1₹XM 2□ F Hours 67 Director 218-34-0327 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Heelth and Mentel Pygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Madical Examinar must be notified at anota. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 No Yes 2 No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 426 North Church Street, Apt. 2B 21788 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 EXYes 2 □ No 1957 – If Yes, Give Year or Dates: 1961 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Metallurgist Steel Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Joseph Michalski Helen Binkowski ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Phyllis Nizer / Executrix 13724 Hillside Ave., Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Jan. 21. 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Crematory 2007 Frederick, Maryland 22. Name and Address of Fecility
Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Funeral Service Licenses 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Pert1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): 10 years Examiner Examiner Atheroscienoric Carpiovascular ettending physician end for use es the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ø Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown DAN dence ģ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 20 No 1 Tes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🛱 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10035152 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thurmont, 100. KranTZ 31. Dete filed (Month, Day, Year)

JAN 2 2 32. Segistrar's Signature State 2007 Registrar

			4 101	partment of Health and Mertificate of Death		iene	
	JE 18.	6	Decedent's Name (First, Middle, Last)		2. Date of Deat	n ZUU	3 Time of Death
i.	Physici /Medic		Robert G. Matthies, Sr.		Month January	Day Year 18, 2007	2:10 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	alaska ariika ariika ar		Golden Living Nursing Home	Frederick		Frede	rick
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign country)
	Director		064−12−0034 149 85 Yrs  Usual Residence of Decedent		Feb. 21	, 1921 New	York
	land ow at		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Mary -f sh fied a	ţo	Maryland Frederick Freder	rick			1 □Yes 2 No
	r 28a	Directo	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What C	ountry?
	th with		2502 Driftwood Ct., Apt. 1-D	21702		United S	States
	ems er mu	Funeral		<ol> <li>Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F</li> </ol>	cify Yes or No-	14. Race - Am Black, Whi	erican Indian,
စ္	, or it		1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:			White
ğ	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at	d by	3122Widowed 4 □ Divorced Year or Dates:	and and a Harris Comment			
1215-0036	n 72 ' "nat ledica	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of workin e. DO NOT use retired)	ng	16b. Kind of Business	s/Industry
7	withi iene. thar the M	m <sub>o</sub>	College (1-40r 5+)	river		Local Gov	zarnmant
0	ifiled I Hyg other ent, i	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N		eriment
land	Ald be Alenta rked tic ev	To B	William Matthies	Elizabeth	Hennin	g	
Mary	12 should be filed v h and Mental Hygie 7 is marked other t iraumatic event, th	_	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Rural	Route Number,	City or Town, State,	Zip Code)
-	is 1 and 2 should of Health and Mer frem 27 is marke other traumatic		Robert G. Matthies, Jr. / Son 123	06 Catoctin Springs	Rd., M	t. Airv. M	m 21771
9	of He of Herr			position (Name of Januar		20c. Location - City or	
Saitimor	Pag ment ant: I		4 Donation 5 Other (Specify) Resthav	en Crematory 200	07 1	Frederick,	Marvland
g	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Resthaven Funeral Se	ervices.	Skkot Co	dy P.A.
D —	2 4 4 5 5		11/1/	9501 Catoctin Mtn. H	Hwy. Fre	ederick, M	D 21701
			23a. Part1. Enter Indian se, of implications that caused the death. Do not shock, or in ure. List only of cause on each line.	enter the mode of dying, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Pneumonia				Onset and Death  2 weeks
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	- Xuiiiiiiiiii	<u>_</u>	Sequentially list conditions, b.				
_	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Cause Chieses of this				
E.	xecur and al-trar	Examiner	that initiated events resulting in death) Last C				
00/0	icate be executed physician and s the burial-transit	dical E					
00	The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edic	d				
Š	w requires that the death certificher is signed by the attending is should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of de	livery
Ď	death a atte d for	icia	in the past 12 months?	B □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
5	t the by the ache	hys	9 ☐ Unknown 9 ☐ Unknown				
ָר ר	s tha	y P	Part II. Other significant conditions contributing to death but not resulting in the	, ,	23e. Did tob	acco use contribute to	o the cause of death?
cords,	en sig	ed k	Cerebrovascular Accident, Dementia,	Hypertension	1 ☐ Ye	s 2⊠No 3∏P	robably 4 □Unknown
ຽ	law re as be 2 sho	plet			24a. Was an		utopsy findings available
	The ate his page	Completed by			autopsy perform 1 Yes 2	ned? death?	completion of cause of 2 ☐ No
ō	stan: ertific ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death			20110
_	hysic his ce I dire	To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ent 3 DOA Other; 4 Nursing Hom	e 5 ☐ Reside	nce 6 □Other (Spe	ocify)
5	ing P		27. Manner of Death   28a. Date of Injury   28b. Time   1 ☑ Natural   5 ☐ Pending   (Month, Day Year)   Injury   Injury   1 ☑ Natural   1 ☑		Bd. Describe hor	w injury occurred	
2	tendi eath. tor: A the fu	cati	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	or At fler d Direct in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	Bf. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	pital ours a eral [		29a. Certifier 1123 Certifying Physician: To the best of my knowledge, de	ath account of the time date and day			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier  (Check only one)  1XX Certifying Physician: To the best of my knowledge, de  2	investigation, in my opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner at ate and place, and du	s stated. e to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	th, Day, Year)
· A			Seens El SeduM	D 30496	J	an. 18, 20	007
1	0		30. Name and address of person who completed cause of death (Item 23a) (Typ	a, Print)			
			Frances E. Becker, M.D. 300 W. 9th S		D 21701		
	Sta	-	31. Date filed (Month, Day, Year)  JAN 2 2 2007	Societé s			
	Registr	ar	JAN 2 2 2007 Blown St.	The state of the s			

DHMH 17 Rev 1/2001

			1- For State of Maryland / Department of He Registrar Certificate of D			iene 007	03048
ø	Physici	4	WIIII II I I I I I I I I I I I I I I I		2. Date of Deat January		3. Time of Death 5:45p M
	/Medic Examin		Ab Che Town and			4c. County of Death Montgomer	У
	Funeral Director	845	5. Sociaf Security Number 5.77 56 2778  6. Sex 1 M 2 F  7. Age (In yrs. last birthday) Months Days  6. Sex 7. Age (In yrs. last birthday) Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 0570271		olace (State or Foreign
	r 28s-f ehow	irector	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  DC Washington  10e. Street and Number 10f. Zip Code			0g. Citizen of What Cour	
36	2 should be filed within 72 hours after death with the Maryland and Menial Hygene. Is marked other than "naturel", or Itema 23s or 28s-f show aumatic event, the Madical Examinating the notified at	by Funeral Director	643 Franklin Street, NE  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent of His If Yes, specify Cuban 1 Yes, Give Year or Dates:	spanic Origin? (Spe , Mexican, Puerto f Specify:	cify Yes or No-	United Stat  14. Race - Americ Black, White, Specify: Blace	ean Indian, etc.
Maryland 21215-0036	within 72 hour ene. than "naturel he Mad cal Ex	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Construction	uring most of workir	ng	16b. Kind of Business/In-	dustry
land 2	0 = 0 \$	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name Elizabet		· ·	
	and 2 shouath and N 27 is mai		19a. Informant's Name/Relationship (Type, Print)  Mary Pratt Wife  19b. Mailing Address (Street are 19b. Mailing Address)  19c. Mailing Address (Street are 19b. Mailing Address)	t., NE Wa			
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if Item 27 is marked any Injury or other traumatic a <u>pnce</u> .		20a. Method of Disposition  1	01/19	9/2007	20c. Location - City or To	DC
Ball	Departition Departition Departition Departition Department of the		21. Smature of Funeral Service Licenses  22. Name and Address 3015 12th S  23a/Part1. Enter the disease, or complications that caused the death. Do not enter, the modify of dying	t., NE Wa	ashingto		
	The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate and certificate as the burial-transit certification.	dicai Examiner	shock, or heart failure. List only one cause on each line.  If immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Entar Understanding that initiated events resulting in death) Last  Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	lmen nia stili	alej	Quest	Interval Between Onset and Death
.O. Box 6	that the death certificated by the attending placed by the attending placed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of delive Month	ery Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.		pacco use contribute to the sacco use contribute to the sacco use contribute to the sacco use to the sacco use contribute to the sacco use co	
I Reco	The law recate has be page 2 she	Completed			24a. Was a autops perform	y prior to co	psy findings available mpletion of cause of 2 No
Vita	dcian: Th	Be	examiner? Hospitat -	26. Place of Death			
Division of Vital Records,	ding Phys n. After this funeral di	tion: To	1 Tes 2/100 1 Inpatient 2 ER/Outpatient 3 DOA	at 2		ence 6 Other (Specification of the second of	()
Divisi	lal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (St City or Town	reet and Number or Rura n, State)	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinand manner stated.	inion, death occurre	ed at the time, d	ate and place, and due to	the cause(s)
	Veith To Con	Σ				9d. Date signed (Month,	•
•				5617	/	1-15-2	1001
)	(6)		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  DR. MASIREEN KANGO 7616 CARROLL AVE	- JAKON	nd Pan	k. mb. 5	20912
	Sta Registi		11. Date filed (Morrill), Day, Take				

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician MATTIE VIRGINIA ROYSTER 17 2007 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 87 Director 577-18-5296 07-20-1919 BROOKNEAL, VA Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at XXYes 2 □ No Director DC WASHINGTON 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 20017 808 CRITTENDEN STREET NE USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X No Specify: BLACK Specify: Completed by 3 Widowed 4 □ Divorced er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NAVAL RESEARCH LAB/ Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT CUSTODIAL LABOR 8TH Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f LIZZIE ANN MARSHALL ROBERT WESLEY SMITH မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 6100 WESTCHESTER PARK DR, #812, COLLEGE PARK, MD JOSHUA C. ROYSTER, JR/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State FORT LINCOLN CEMETERY 1-27-2007 BRENTWOOD, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FaMARSHALL'S FUNERAL HOME OF MD, INC 4308 SUITLAND RD, SUITLAND, MD 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cer Le 40 cas ala disease or condition resulting in death) Ranuteo /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed aftending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 ☐ Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by lieng abstructure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an has autopsy perform page Imbalance. Dehydration certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 YNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending (Month, Day Year) 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

within 24 hours af

To the Funeral D

completely filled in the Hospital 10 State Registrar

31. Date filed (Month, Day, Year) JAN 2 2 2007

(Check only

29b. Signature and title of certifier

MD, 6132 LANDOVER RD, CHEVERLY MD, 20785 RAVINDER K. RUSTAGI, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

024720

29d. Date signed (Month, Day, Year)

1-18-07

07-00448 Nakeeda Rice

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of D		, ,	g. No. 2111	7 0305
Physici Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month January 16	h	3. Time of Death
, and		4a. Facility Name (if not institution, give street and number) 4b. (	City, Town, or Location of Dea		4c. County of Death	
Funeral			Sambrills  f Under 1 Year   If Under 24H	- To Date (10 a)	Anne Arundel	
Director			f Under 1 Year If Under 24H Months Days Hours Mi	January	h(MM/DD/YYYY) 9. Bir 7 18, Foreig Co	mMaryland untry)
' any		10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
Vlaryland 28a-f show any d at once,	ţor	MD Prince Georges Bowie				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	al Director	4906 Collington Road	Of Zip Code 20715		g. Citizen of What Cour	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, s	ecedent of Hispanic Origin? ( s specify Cuban, Mexican, Puert s 2 X No specify:		. 14. Race - Ameri White, etc. Blace	
ours af atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's U	Jsual Occupation (Give kind of		Specify: 16b. Kind of Business/l	ndustry
vithin 72 h ene. er than "n Medical E	Completed	12th Unemplo	of working life. DO NOT use re	etired)	None	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Alton Linwood Rice	Tracy	ne (First, Middle, M We 1	1s	
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is m njury or other traumatic	To	Tracy Rice/ Mother 4906 Co	dress (Street and Number or Dillinton Rd.,	Bowie, M	D 20/15	
ges lantof He		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	olace)	Date	20c. Location - City or	
altim mit Pa partmen portant		4 Donation 5 Other Specify: Resurrection 21. Signature of Funeral Service Licensee 22. Name		22/2007	Clinton, ins Funeral	
		2 D M-hall 747	74 Landover Rd	l., Lando	ver, MD 20	785
Physician /Medical xaminer		Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.     Immediate Cause (Final disease a. Multiple Injuries.	ode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	Н	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	-			
uted 1d ransit		events resulting in death) Last  Due to (or as a consequence of):  d.				
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED				
68760, certificate be iding physic se as the bur	In/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal december 12 months?	leath 3 Ectopic pregn	nancy	23d Date of delivery	ay Year
Box 687 re death certification attending red for use as t	ysician/	Pregnant at time of death	(Specify)			, , , , , , , , , , , , , , , , , , , ,
ries that the signed by the detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		acco use contribute to t	
of Vital Records,  ng Physician: The law require the control of th	Completed			24a. Was ar	24b. Were aut	opsy findings available
Reco The law cate has	omp			autops perforn 1 ✓ Yes 2	ned? death?	ompletion of cause of
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n of Vi ing Physi After this uneral dir	ြ	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3  27. Manner of Death 28a. Date of Injury 28b. Time of Injury			tesidence 6 Other	Scene
tion c trending death. tor: Af	ation	1 Natural 5 Pending FOUND: 1210 hrs	1 Yes 2 ✓ No	Driver auto fi	xed object collision	1
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and realy filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway	ctory, office building, etc.	or Town, Sta	reet and Number or Rur ate) Crossing Rd, Gambr	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical (	29a. Certifler 1 Certifying Physician: To the best of my knowledge, death occurred a cone 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated.	at the time, date and place, and in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as state nd place, and due to the	d cause(s)
LSEO	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon.	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		January 17, 2007 —–	
-(5)	ل		et, Baltimore, MD 2120	1		
St Regist	ate rar	31. Date filed (Month, Day, Year) 7 See 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) WILLIAM L. READ JANUARY 16 2007 10:52 AM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days 1 □**X**M 2 □ F 80 NEW YORK 350-20-9375 JULY 8, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD TALBOT EASTON 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21601 USA 7058 THOMAS LANE Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MILITARY VICE ADMIRAL NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARTHA LAWRENCE REGINALD A. READ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7058 THOMAS LANE, EASTON, MD 21601 MARTHA M. READ/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) U.S. NAVAL ACADEMY CEM. 1/23/2007 ANNAPOLIS, MD 21. Signature of Fuheral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ivansitional Cell Concer of yeas: disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 INO 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No HOSPICE 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 ☑Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 442587 01-17-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A Schilling & 555 Cynwood Drive Easton Ms 21601

10+ VA

To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu

State Registrar

DHMH 17 Rev 1/2001

**Physician** 

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Examiner

Director

Funeral

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**Funeral** 

Director

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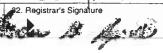
Division of Vital Records, P.O.

21215-0036

Maryland

31. Date filed (Month, Day, Year)

JAN 1 8 2007



**ORIGINAL** 

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici	anl	1- For State Registrar  1. Decedent's Name (First, Middle, Last)  Certificate of Dea	ath	Reg. No. 2007 0305
Medical Exam		Ramon Resto-Gonzalez	2. Date of De Month January	eath Day Year 27, 2007  3. Time of Death 1307 hrs
		400 Dames and 1 A	, Town, or Location of Death	4c. County of Death  Carroll
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un 1584-42-7504 1 1 M 2 F 53 Yrs.	nder 1 Year If Under 24Hrs. 8. Date of B	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Puerto Country) Rico
Aaryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Carroll  10c. City, Town or Location	Westminster	10d Inside City Limits 1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	al Director		21157	10g. Citizen of What Country?  USA
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	by Funeral	1 3 Midowood 1 Divorced Iff Voc Civo Voor	- NICUII	White, etc. Specify: White
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed by	Elementary/Secondary (0-12)  10  College (1-4 or 5+)  Line	al Occupation (Give kind of work done orking life. DO NOT use retired)  Worker	16b. Kind of Business/Industry Telephone Company
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be Co	Rafael Resto	18. Mother's Name (First, Middle,  Maria Teresa	Gonzalez
MD td 2 sho tlth and m 27 is aumati	Lia	Clara Resto-Gonzalez, sister 308 Hamme	s (Street and Number of Rural Route Nu ershire Road, Reist	erstown, MD 21136
Pag Pag ant:		Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  Crematory or other place  St. Paul's Co	emetery 02/01/2007	
(		Just R. Duloran 91 W.	illis Street. Westm	rboraw Funeral Home inster, MD 21157
Physician /Medical Examiner	/	23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxication  Due to (or as a consequence of):	of dying, such as cardiac or respiratory ar	rest, shock, or heart Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated		
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ox 68' ath certiff attending or use as t	sician	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spe	3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
S, P.O. uires that the signed by the detache	5	Part II. Other significant conditions contributing to death but not resulting in the underlying		obacco use contribute to the cause of death?  s 2 No 3 Probably 4 Unknown
of Vital Records, ig Physician: The law require the this certificate has been sineral director, page 2 should be	Completed		24a. Was autop perfo 1 ✓ Yes	prior to completion of cause of death?
Vital hysician: this certif	o Be	Hospital:	26.Place of Death (Check only one)  OA Other Nursing Home 5	Residence 6 ✔ Other Scene
sion of vitending Ph death. ctor: After t	-1	OZ Marris (D. 1)		how injury occurred
Division Hospital or Attendia 24 hours after death Euneral Director: A	Certification:	3 Suicide 6 X Could not be determined (Specify) Sound at residence	or Town, S Westminst	
To the Hospital within 24 hours To the Funcral completely filled	edica	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred at the time, date	se(s) and manner as stated and place, and due to the cause(s)
MIL		hy hi, mid	O.C.M.E.	29d. Date signed (Month, Day, Year)  January 28, 2007
	1	Name and Address of person who completed cause of death (Item 23a)     Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201	
Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 0 2007  32. fegistrar's Signature		
D.N., Re	0	ORIGINAL		

OCME 2006

			1 = For State Registra/Amend #26.PenPh	State of Mar		artment of F		-	giene Reg. No 200	7 03054
	Υ,		Decedent's Name (First, Middle, Last)	)				2. Date of De.	ath	3. Time of Death
	Physici /Medio		Mildred I. Sv	wann				Januar	Day Ye	
4	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	th	4c. County of D	eath
			8804 Junaluska				inton		Prince	Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (i ]M 2 🔀 F	n yrs. last birthday,	Months Days	Hours Min	. (Month, Da	th ly, Year) 9.	Birthplace (State or Foreign Country)
н	Director		577-46-2840 Usual Residence of Decedent	3 294.	72 Yrs.			Aug.3,	1934 W	ash.,DC
	pue M.		10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	f aho	5	Md DC		Clinto	n				1 ∰Yes 2 No
	28a-	Director	Md . PG  10e, Street and Number		CITICO	10f. Zip Code			10g. Citizen of What	Country?
	hours after death with the Maryler tural', or Items 23e or 28e-f ehow al Examiner must be notified at	٥	8804 Junaluska	Шоммада			) F		Trade a d	
	ns 2%	by Funerai		12. Was Decedent Eve	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No	United S	merican Indian,
(0	ritar	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo				rto Rican, etc.)	Black, W	hite, etc.
8	e since	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: E	lack
21215-0036	n 72 hours after death with the Marylend "natural", or Itams 23a or 28a-f ahow isoloal Examinat ha molified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation during most of we	orkina	16b. Kind of Busine	ss/Industry
2	within 900.	혈	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	3)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	77 75 1	ဉ် ပ	12			Clerk			Governm	ent
P	生工 品 胃	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ime (First, Middle,	Maiden Surname)	
ya	Men at c	ပု	Samuel Morgan					Childre		
Maryland	2 short and is m	1.8	19a. Informant's Name/Relationship (Ty						er, City or Town, Stat	e, Zip Code)
-	s 1 end f Heelth item 27 other t	1	Reginald Swann/		Wald 20b. Place of Dispo	O Tiffe	2060	T	200 Leasting City	as Taura Ctata
0	0 = 5		20a. Method of Disposition 1 分 Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemetery, cre	matory`or other plac			20c. Location - City	
Baltimore	permit. Pag Depertment Important: any Injury once.	١,	4 ☐ Donation 5 ☐ Other (Specify)		Md. Vete	erans Ce	m.   1/:	23/07	Cheltenh	am, Md.
3a	permit. Depertrimportri		21. Signature of Funeral Service License	99 5 - A	1 ) 2	2. Name and Addre	ss of Facility	Hodges	& Edward	s F.H.
	70 F # 0		Junice C	Muan						,Md.20746
1	Physician	-	23a. Pagri. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	5	ter the mode of dylr	ig, such as cardia	ic or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	1	1			7 - 10,711
	Examiner		Sequentially list conditions, if any, leading to immediate		etastas	as +1 -2	erzin	2 lim	1	
	p #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):	-		-		
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a c	mal 7	ancure				1 mante
8760,	cien cien			Due to (or as a c	onsequence on.					
87	physicate I	dicai		1			<u> </u>			
9 x	death certificate e attending phys d for use as the	/Med	IF FEMALE:	3c. If yes, outcome of	regnancy				221 5	4.15
Вох	atten for us	Physician/M	in the past 12 months?	1 ☐ Live birth 2 { 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	Day Year
	by the de	ysic	1 ☐ Yes 2 🔀No 9 ☐ Unknown	9 Unknown	ie or death 5	Other (specify)				
P.0	The law requires thet the site has been signed by the bage 2 should be detached.		Part II. Other significant conditions con	ntributing to death but r	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	signed d be del	d by	Carren 6	Indem 1	Dominal	2		1 🖫	les 2 □No 3 □	Probably 4 Unknown
Š	w requir been s should	Completed	11	11 11) 4				24a. Was	245 Word	autopsy findings available
ee.	hes hes	m m	- Stypertines	FEF				autop		to completion of cause of
<u></u>			OS Management and an addition					1 Tes	2 <b>½</b> No 1□1	′es 2⊠ No
Vital	Physicien: T this certificet ral director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	-2 TAEP/Outpatier	oth Oth	00	eath (Check only o		
ō	ding Phys h. After this funeral dir	1: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day Y		11 30 000	4 🗆 Nursing		dence 6 Other (S	ресіту)
on	ding th.	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	e <i>ar)</i> Injury		k? Yes 2∐No			
Division	Attanding r death. actor: After by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, str	reet, factory, office				Rural Route Number,
Ö	or Att efter d Direct d in by	Certification:	4 Homicide	building, etc. (	Specify)			City or Tow	vn, State)	
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai C	29a. Certifier 1 Certifying Phys	sician: To the best of n	ny knowledge, deat amination and/or in	h occurred at the tir	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and	as stated.
	Vithin 24 within 24 To the Fu	Med	one)	and manner stated	1.					
	T vit		29b. Signature and title of certifier		m	250. 200115	5 100 -	<i>,</i>	Lou. Date signed (MI	our, Day, (ear)
	0		1 / pory un	"	12)	1)-	20829	Z <sub>a</sub>	1/19/0	7
0	151		30. Name and address of person who co	empleted cause of deat	h (Item 23a) (Type,	Print)	TEIA 1	1	MIN	onth, Day, Year)
				1 1 1 1 VI 7-Q	au U.Fri	1. move	TIX U	MORK	1/ WKIDOK	A ((11/0/177)
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's	Signature -	, , , , ,		7-		9

#### 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Staton Annie Janua-ry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctors Hospital Lanham 8. Date of Birth (Month, Day, Year) Dec. 12, 1933 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1 ☐ M 2 🔀 F 73 239-48-5637 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f sh Examiner must be notified MD Bowie Director Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20716 U.S.A. 3850 Enfield-Chase Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2X XIO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo be filed within 72 hours af tal Hygiene. d other than "natural", or Specify. Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F Be be f Rebecca James Smith ္ရ and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ikey P.Staton Sr.-Husband 3850 Enfield-Chase Court, Bowie, MD. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Mem.Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important; If Ite any Injury or ot once. N Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.24,07 Suitland, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hunt Funeral Home 21. Signature of Funeral Service Licens 908 KEnnedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner

Approximate Interval Between Onset and Death 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last as a consequence of IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♣ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 (☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 | Inpatient 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the cause of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Year 2007

Black, White, etc.

Kiah

29d. Date signed (Month, Day, Year)

9. Birthplace (State or Foreign Country)
N.C.

10d. Inside City Limits

TX Yes 2 No

2 State

the death certificate be executed

physician

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After

the Funeral Director: moletely filled in by the

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Hospital 24 hours

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Box 68760,

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or Vital Records,

Exami

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hero

DHMH 17 Rev 1/2001

Registrar

500d

32. Registrar's Signatu

29c. License number

1100 51398

Luck Road, Lanham

07-00669 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael John Sparks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 23, 2007 Medical Examiner 2327 hrs Michael . John Sparks 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's Ft. Washington Hospital FT. Washington If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex Age (In yrs\_last birthday) **Funeral** oreian Months Days Hours Director 577-64-5672 60 1 X M 2 Dec. 25, 1946 cwashington, DC Yrs Usual Residence of Decedent 'n 10c. City, Town or Location 10d Inside City Limits 28a-f show Westmoreland Yes 2 XXNo Virginia Colonial Beach notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 Bancroft Avenue 22443 USA items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian, Black Armed Forces? 1 Never Married 2 XX Married White, etc. Give Year 1966-1968 White Widowed Divorce Yes 2 XX No specify Specify Š 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than "... event, the Medical Construction Itimore, MD 21215-0036 Plumber | 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Elizabeth Harless Paul Gerald 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincy Sparks / Wife 1401 Bancroft Avenue Colonial Beach. Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XXSurial 2 Cremation 3 partment o ./29/2007 Resurrection Cemetery Donation 5 Other Specify Clinton, Maryland Inature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure List only one cause on each line en Onset and /Medical Death Cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and ca X UNPENDED **AMENDED** #23a,PII,27,28a-f, perME, g864, 2/6/07 TT Physician/Medi Box 68760. ing phys as the b IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Atherosclerotic cardiovascular disease Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital. 1 Other4 Inpatient 2 V ER/Outpatient 3 this DOA Nursing Home 5 ٩ 1 🗸 Yes 2 No After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b, Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 X No 5 Pending Fnd 1/23/2007 Fnd 11:10 pm unknown 2 Investigation Accident 28f Location (Street and Number or Rural Route Number City or Town, State) 401 Bancroft Ave. 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 X Could not be Suicide determined (Specify) found in house Homicide Colonial Beach. 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal the the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ,0 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. January 24, 2007 CITTURIO 30. Name and address of person who completed cause of death (Item 23a)

State Registrar Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Joseph Lavelle Thompson

		1- For State Registrar	- Or Iviaryland		ite of Dea		ai i iygicii	Reg N	10 200	7 1305
Physici Medical Exami		Decedent's Name (First, Middle, La     Joseph     L	· ·	Thompso	n		Mont	of Death th Da	y Year	3 Time of Death 0910 hrs
,		4a. Facility Name (if not institution, gi				Town, or Location of		uary 17, 2	4c. County of Deat	
		2208 Vermont Avenue		-	Land	dover			Prince Georg	e's
Funeral Director		Social Security Number     6. S	,	In yrs. last birth	day) If Un	der 1 Year   If Under this Days Hours	Min		IM/DD/YYYY) 9. Bi Forei	rthplace (State or gn New York puntry)
5.100101		Usual Residence of Decedent	M 2 F 25	)	Yrs.		Oct	ober	2,1981	ountry)
any		10a. State 10b. County	10	Oc. City, Town o	r Location				<del></del>	10d. Inside City Limits
land f show	ō		Georges	Hyatt	sville					1 X Yes 2 No
th the Maryland 23a or 28a-f show any notified at once.	Director	10e. Street and Number				p Code		10g. (	Citizen of What Cou	ntry?
ith the 23a o	a D	6706 Stanton Rd.	12. Was Decedent Ev	ver in II S		0784 lent of Hispanic Origin	2 / Capaifu Va	0.04 No.	USA	ine telles Black
leath v r items	Funeral	1 X Never Married 2 Married	Armed Forces?	No No		cify Cuban, Mexican, P			White, etc.	rican Indian, Black,
0036 within 72 hours after death with the Maryland jene. rer thau "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	by F		d If Yes, Give Year		1 Yes	2 X No specify:			Specify: B1	ack
hours "natur	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade compl College (1-4 or 5+)	d		l Occupation (Give kir orking life. DO NOT us		e 16t	Kind of Business/	Industry
336 thin 72 ne. thau edical	Completed	12th	Conlege (1-4 of or)	′	Telema	rketing			Private	ļ
5-0 iled wi Hygier Jother the M		17. Father's Name (First, Middle, Last				18.Mother's	Name (First, M	liddle, Maid	en Surname)	
21215-0036 should be filed within 721 and Mental Hygene. is marked other than "atte event, the Medical E	o Be	Jeffrey I. Sm: 19a Informant's Name/Relationship (		19h	Mailing Address	Chri			npson	7 · 0 · do)
_ 0 0 0 5			on / Mother			nton Rd.,				
ore, MD es I and 2 sh of Health an If item 27 is		20a. Method of Disposition  1 X Burial 2 Cremation 3	Pomouni from State	20b. Place of		me of cemetery,	Date		c Location - City or	
Pages Pages nent of lant: If		4 Donation 5 Other Specify			ection	Cemetery			Clinton,	2
Baltimo permit Page Department ( Important: injury or otl		21. Signature of Funeral Service Licer	nsee			d Address of Facility				
Physician		23a. Part I. Enter the disease, or com	olications that caused the	e death. Do not		Landover R of dying, such as care				785 Approximate Interval
/Medical	1	failure List only one cause on e	ach line Multiple Gunshot	Wounds						Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequ							
Marie Care Care Care Care Care Care Care Car	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):						+
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executed an and al - transit		events resulting in death) Last		Jerioc Gry.						
	Medical	UNPENDED	AMENDED							
8760, ificate be up physicials the burials.		IF FEMALE. 23b. Was decedent pregnant in the	23c. If yes, outcome		Fetal death	3 Ectopic p	reanancy	2	3d. Date of delivery	y Day Year
eath certifications are as	sician/	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant at tim	2 l ne of death 5	Other (Spe		regriatioy		Mona	nay real
O. Box that the death of the by the atten detached for us	Phys	Part II. Other significant conditions	9Oriknown	ut not resulting	in the underlyin	g cause given in Part I	230	Did tobaco	o usa contributa ta	the cause of death?
P.O.	Ď		contributing to double by	at not resulting i	in the diagram	g cadae given in raiti				pably 4 Unknown
ords, w requir	etec							. Was an		topsy findings available
Reco The law cate has	Completed		<del>, , , , , , , , , , , , , , , , , , , </del>				-	autopsy performed Yes 2		completion of cause of
Vital Rec ysician: The his certificate director, page	au l	25 Was case referred to medical examiner?				26.Place of Death (Ch			10 10 10	5 2 140
of Vital Records, ng Physician: The law requir the this certificate has been si neral director, page 2 should t	To B	1 🗸 Yes 2 No	Hospital: 1 Inpatient				lursing Home		dence 6 🗸 Other	Scene
nn of ading Pl th : After e funera	in oi	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury FOUND:	)   286. Til		28c. Injury at Work?  1 Yes 2 ✔ N	Subjec		njury occurred	
Division al or Attendin rs after death al Director: A	ficat	2 Accident Investigat	28e Place of Injury	0905 I y - At home, farr		y, office building, etc.		ation (Street	and Number or Ru	ral Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	Suicide 6 Could not determine		valk/steps			or T	own, State)	enue, Landover, M	,
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier 1 Certifying Physic (Check only one) 2 ✓ Medical Examine	ian: To the best of my ki							
To the within 2 To the complet	Medi	29b. Signature and title of certifier	and manner stated.			c License number	red at the time		Date signed (Mor	
	-	1ada A	Je out 1	CU		O.C.M.E.			nuary 18, 2007	
	ŀ	30. Name and address of person who	completed cause of deat	th (Item 23a)						
2/4/			Assistant Medical I		111 Penn S	Street, Baltimore	, MD 2120	1		
St Regist	ate rar	31 Date filed (Month, Day, Year) JAN 2 2 2007	32. Registrar's	Signature .	B					
			Newser N							

		•	For Stata Registrar	State of N	/larylan		artmer rtificat			and Me		giene Rag. No.	200	7	03058
4	*** **		1. Decedent's Name (First, Middle			m					<ol><li>Date of Dea Month</li></ol>	Day	Ye	ar	3. Time of Death
	Physici /Medic		Mavis	Eloise		Tait					January	$\overline{}$			11:05 PM
	Examin	_	4a. Facility Name (If not institution,					Town, or nham	Location o	f Death			County of E		orges
140	37		Magnolia Garden  5. Social Security Number			last birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birtl				lace (State or Foreign
	Funeral Director		084-22-3898	1□M 2⊠F	86	Yrs.	Months		Hours	Min.	8. Date of Birtl (Month, Day January	, Year)		ana	try)
	D C		Usual Residence of Decedent					1							
	how		10a. State 10b. County			y, Town or Lo								1	0d. Inside City Limits 1 Yes 2 □ No
	Be-1 s	cto		e Georges	GLe	nn Dal	-					10- 01	zen of Wha	1.000	
	with th	by Funeral Director	10e. Street and Number	T			10f. Zij	769				US.		t Coun	ury :
	e 23e	grai	10915 Legend Man	nor Lane	at Ever in U	S 13			spanic Orig	nin? (Spec	offy Yes or No-		14. Race - /	Ameno	an Indian,
	ler de	-E	11. Marital Status  1 □ Never Married 2 □ Marri	Armed Force:	s?		If Yes, spe	cify Cubai	n, Mexican	, Puèrto P	lican, etc.)		Black, V		
99	urs a	by	3 ☐ Widowed 4 ☑ Divorced	ff Yes, Give Year or Dates			1 ☐ Yes	2X No	Specify:				Specify:	рта	
21215-0036	within 72 hours after deeth with the Maryland ane. than "natural", or Iteme 23e or 28e-f ehow ta Mexical Exacting mail to notified at	Completed	15. Decedent (Specify only highes	's Education t grade completed)			kind of wo	ork done a	lu <i>ring m</i> osi	t of workin	g	16b. Ki	nd of Busin	ess/Ind	dustry
2	hen.	mpi	Elementary/Secondary (0-12)	Colfege (1-4o	or 5+)		DO NOT I		g Ass	sicto:	nt	G	overni	nen	t
2	Hygie Ther t nt, m	ပိ	17. Father's Name (First, Middle, I	2yrs		Loan	DOL	/10111			(First, Middle,				
Maryland	d be	To Be	John Lewis	,					Miri	lam	F	1111			
چ	shoul nd Mo marl marl	ř	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Addres	s (Street a	ind Numbe	or or Rural	Route Numbe	r, City o	r Town, Sta	te, Zip	Code)
Ž	alth a		Claudette Taut-	Randolph/Da	ughte	r 1091	5 Leg	gend	Manor	Lan	e, Gler	n D	ale, 1	ID_	20769
ore,	of He of He Item		20a. Method of Disposition  1 X Burial 2 Cremation	3 □ Bonaval from Sta		lace of Dispo emetery, crea	matoni or	other place	9) 1		ate		cation - Cit		
<u>Ĕ</u>	Page ment ant: It		4 Donation 5 Other (Sp		Kee	urrect									ryland —————
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iteme 23a or 28e-f show any Injury or other traumatic event, It a Medical Exacting must be notified at once.		21. Signature of Funeral Service	15/			7474	Land	over	Rd.,	. Jenki Landov	er,		a1 1 207	
÷ 1			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the deat	A. Do not ent	er the mo	de of dying	g, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition	Fata	1 Car	diac A	rrhyt	hmia							Onsot and Doath
	/Medical Examiner		resulting in death)		as a conseq										
90pc	LAdminer	Ŀ.	Sequentially list conditions,		brova	scular	Acci	ldent						+	
	ted nsit	nlne	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	\$ 10,010	20 2 00004	201100 01,1									
	execu n and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	as a conseq	uence of):									
8760,	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rall director, pege 2 should be detached for use as the burial-transit	call	13	d											
9	ntifical og ph as th	Physician/Medical	fF FEMALE:												
Вох	that the death certific ed by the attending p detached for use as	an/N	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcom 1 ☐ Live birth		Ideath 3	]Ectopic p						23d. Date o Month	delive	ery Day Year
0	the at	/slci	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 □ Pregnant 9 □ Unknown		leath 5	Other (s	pecify)							,
<u> </u>	that the		Part II. Other significant condition	ens contributing to death	n but not res	ulting in the u	inderlying	cause give	en in Part I.		23e. Did to	obacco u	ise contribu	te to th	ne cause of death?
Records,	uires tha signed l id be det	d by		_		_					101	es 2	<b>∑</b> No 3[	Prob	ably 4 Unknown
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Be	he lav e hes age 2	m c							-			isy rmed? 2 <b>X</b> No	dea	th?	mpletion of cause of 2⊠ No
ta	an: T tificet tor, pe	0	25. Was case referred to medicat						26. Place	of Death	(Check only o				223110
<u> </u>	yeici is cer direc	To B	exa <i>m</i> iner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ fnpa	atient 2	ER/Outpatie	nt 3 D	OA Othe	er: 4∱ Nu	irsing Hom	ne 5□Resid	dence	6 Other (	Specif	y)
0			27. Manner of Death 1 ⊠ Naturaf 5 ☐ Pendin	28a. Date of fi	njury Day Year)	28b. Time of Injury	ıf	28c. Injury Work			8d. Describe h	now injui	y occurred		
sio	Attending or death. ector: Alte by the fune	atle	2 ☐ Accident investig	gation			М		Yes 2 🗆						
Division of Vital	5 th 5	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of	In <del>i</del> ury - At h etc. (Specil		reet, facto	ry, office		2	City or Tox			or Hura	d Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the be Examiner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred vestigatio	d at the tin n, in my or	ne, date an pinion, dea	id place, a ith occurre	nd due to the	cause(s) date and	and manne I place, and	er as si due to	tated. the cause(s)
	vithin 2 To the	Mec	29b. Signature and title of certifier				29	c. License					e signed (A		Day, Year)
	F S F Ö		1 XIII	-	MD			D6	1446			1	/19/20	007	
•	(10)		30. Name and address of person	who completed cause of											
1	9			vanar M.D.	9470	Annapo	olis	Rd.	#315 <b>,</b>	Lanh	nam, Ma	ry1a	nd, 2	070	16
\$ 78 \$ 78 \$ 78	Sta Regist		31. Date (fied (Month, Day, Year)	32. Regi	strar's Signa	Spell	7								

DHMH 17 Rev 1/2001

			For	State	of Mar	yland / E						ental Hy		000	1 00050
			State Registrar				Cer	tificate	OT L	Jeath			Reg. No.	200	3. Time of Death
	Physicia		Decedent's Name (First, Middle	, Last)							1	<ol><li>Date of De Month</li></ol>	eath Day	/ Year	
	/Medic	al	Katherine	I.	Trou	ıt	1					Januar		5, 2007	
i	Examin	er	4a. Facility Name (If not institution		d number)		1	4b. City, T					46.	County of Deat	
			Northhampton M	lanor 6. Sex	7 400	In yrs. last bir	thday)	If Under 1		rick If Under		8. Date of Bi	rth	Freder 9. Birt	hplace (State or Foreign
	Funeral		5. Social Security Number 219–46–3496	1 M 2 J			Yrs.		Days	Hours	Min.	July 2	ay, Year)	Co	untry) Maryland
	Director		Usual Residence of Decedent									July	20, 1	. 719	1102 / 11011
	land	Ì	10a. State 10b. County		1	0c. City, Town	n or Loc	ation							10d. Inside City Limits
	Mary Fied a	ō	Maryland Fre	ederick		W	la1k	ersvi	11e						1X∑Yes 2 No
	r 28a	Director	10e. Street and Number		•			10f. Zip (	Code					izen of What Co	
	h wit		30 Fulton Aver	nue						21793				Inited S	
	dear	Funeral	11. Marital Status	Arme	Decedent Ev d Forces?		13. V	Vas Decede Yes, speci	ent of His ify Cuba	spanic Or n, Mexica	rigin? (Spec in, Puerto F	cify Yes or N Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
2	172 hours after death with the Marylar "natural", or items 23a or 28a-f show edical Examiner must be notified at	y Fu	1 □ Never Married 2 □ Mam	If Yes	res 2. X No s, Give		1	☐ Yes 2	X No	Specify	:			Specify:	White
Š	urai",	d by	3 ☐ Widowed 4 ☐ Divorced		or Dates:	16a	Deced	ent's Usual	Occupa	ation			16b. Ki	ind of Business/	Industry
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4	withir ene. than	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)	F	lome	maker	•					Own Home	
2	filed Hygi other ent, t	a	17. Father's Name (First, Middle,	Last)						18. Moth		(First, Middle		Surname)	
ğ	should be filed within 72 hours after death with the Maryland ind Merdla Hygiene. Price in thems 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To B	Claude W. Ge	eisbert							Alic	ce Mic	hae1		
, E	shou ind M inar umat		19a. Informant's Name/Relations		)	19b	. Mailin	g Address	(Street a	and Numb	ber or Rural	Route Num	ber, City o	or Town, State, 2	Zip Code)
Š	and 2 ealth a n 27 is ner trat		Michael Trout	/ Son						one I				k, MD 21	
ני ב	of He of Herr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal	from State	20b. Place of cemete	f Dispos	sition (Nam natory or ot	e of her plac	θ)		ate		ocation - City or	
	Pages nent of h ant: if its		4 Donation 5 Other (S	Specify)	ioni state	Mt. Ho			-		1/19/				, Maryland
2	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mendal Hygene. Important: if ten 27 is marked other than "natur any Injury or other traumatic event, the Medical. any Injury or other traumatic event, the Medical.		21. Signature of Funeral Service	Licensee	/ ,			. Name and						ineral I , MD 217	
<u> </u>	8 3 E E 9		/ owney	Jacy	per		1							, FID Z1	
			23a. 1. Enter the dises se, or shock, or heart failure. List	complication only one cau	on each line	he death. Do	not ente	er the mode	e of dyin	g, such a	s cardiac oi	r respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	a		W 665		H	MAR	TF.	AILU	RE			MONTUS
1	/Medical Examiner		resulting in death)	Du	e to (or as a	consequence	of):								
	xummo:	5	Sequentially list conditions, if any, leading to immediate	b	e to (or as a	consequence	of):								
	led isit	Examiner	Cause (Disease or injury	<	(	4	/-								
	xecul and al-trar	xau	that initiated events resulting in death) Last	C	e to (or as a	consequence	of):								
oc,	death certificate be executed e attending physician and of for use as the burial-transit	ical		d											
00	ificate g phy as the	g													-
XOC	<ul> <li>requires that the death certifica</li> <li>been signed by the attending ph</li> <li>should be detached for use as the</li> </ul>	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		s, outcome p	f pregnancy ! □ Fetal death	h 3[	Ectopic pr	eanancy	r				23d. Date of de	
Ď	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□		ime of death		Other (sp						Month	Day Year
5	requires that the een signed by th hould be detache	hys	9 Unknown									00- Did		una namtaibuta t	o the cause of death?
,	as the	by F	Part II. Other significant conditi												robably 4 Unknown
cords,	equir een si ould I	Ped	CALON.							DISE	ASE	1	100 2		
ပ္	The law rate has be	ple	Deme	WIA (	ALZ	HEIMET	25	TTPE				24a. Wa	opsy	24b. Were a prior to death?	utopsy findings available completion of cause of
<u>r</u>	(0 6	Completed										1⊟ Yes	formed? 2 ☑ No	1 Yes	2 1 No
Vital	clan: ertific	Be (	25. Was case referred to medica examiner?	Hospital:					Oth	or:		(Check only			
20	ding Physician:  After this certific funeral director,	은	1 Yes 2 No		1 Inpatient		utpatier Time o		'A	4463 1		ne 5 Re 28d. Describe		6 ☐Other (Spe	ecify)
	After Anter Anter	io io	27. Manner of Death 1 ☑ Natural 5 ☐ Pendii	ng	(Month, Day	Year)	Injury	M	8c. Injur Worl 1 □	k? Yes 2[		204. 2000112	o non inje	.,,	
Sion	ttend death stor: the f	cat	3□ Suicide 6 □ Could	not be 28e.	Place of injur	y - At home, fa	arm, str				-	28f. Location	(Street a	nd Number or R	ural Route Number,
2	pital or At burs after d eral Direc filled in by	Certification:	4 Homicide determ	nined	building, etc.	(Specify)						City or T	own, Stat	e)	
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifyi	ng Physician:	To the best o	f my knowledg	je, deat	h occurred	at the tir	me, date	and place, a	and due to th	e cause(s	s) and manner a	s stated.
	e Hos 24 ho e Fun letely	Medical	(Check only 2 Medical one)	Examiner: On	the basis of manner stat	examination a	nd/or in	vestigation	i, in my c	opinion, d	eath occurr	ed at the tim	e, date ar	na piace, and du	e to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of cortific	· ·	1	X		290	. Licens	e numbei	r		29d. Da	ate signed (Mon	th, Day, Year)
			•	1	\/	1 ms	)		7	32	171			1/17/0	7
	10		30. Name and address of persor	who completed	cause of de	ath (Item 23a)	(Туре,	Print)							
_	11		RICHARI	-	NGU	Po	Be	32	8	ه ن	-LKER	SUIL	E,	mo 21	793
		ate	31. Date filed (Month, Day, Year			r's Signature									
	Regist	rar	JAN 1	9 2007	Mille	e &	14	marke	P						

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician ISADORA** 10:20 PM WALLS 6,2001 lanuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, APRIL 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 1 1 1914 GOLDSBORO, NC 239-10-9445 92 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 28a-f show 1 X Yes 2 □ No Director MD PRINCE GEORGES LANDOVER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 KENT VILLAGE DRIVE 20785 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes & ZINo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Specify þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ELEVATOR OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENNIE CLARK LIZZIE CLARK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. 11425 HONEYSUCKLE CT. UPPER MARLBORO, MD 20774 GERALDINE WALKER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 14 Burial 2 ☐ Cremation 3 Removal from State MD NATIONAL CEMETERY 1/26/2007 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin 2 months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) physician Physician/Medical the attending properties of the pr 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 🗆 No ed by the detached 9 Unknown 9 ☐ Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsv perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Inpatient 2 ER/Outpatient 3 DOA Date of Injury 28b. Time of 28c Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: s after death. Il Director: Af id in by the fur within 24 hours a To the Funeral C filled

Maryland 21215-0036

altimore,

pe

State Registrar 29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

. Chanda

D16380

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001, Landoner Rd-Cheverly, MD 2078 5 P. CHANDER

🕊 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

JAN 2 2 2007

29a. Certifier

Medical

32. Registrar's Signatur

1 - For State Registrar

ı	Physici	an	CHARLES J. WILSO	NT				Month	Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deatl	Janua	4c. County of Dea	
	LAdillii	161	Memorial Hosp	ital at Ea	ston	Eas	ton		Talb	_
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		rth place (State or Foreign ountry)
	Director		2/8-18-9462	M 2□F 89	Yrs.	World Days	110015 IVIIII.	DEC. 30	, 1917 WAS	HINGTON, D.C
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Aaryli Febo	ō	MD TALBOT		EAST					1 ☑ Yes 2 ☐ No
	188-	Director	10e. Street and Number		EMAL	10f. Zip Code			10g. Citizen of What C	ountry?
	3a or		#20 LYNNBROOK TER	RACE		216	01		USA	•
	deat	Funerai		2. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No		
98	or its	y Fu	1 ☐ Never Married 2 ☒ Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 ဩ No		o rican, etc.)	Black, Wh	ite, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Items 23s or 28s-1 show event, the Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						WHITE
15	in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	durina most of wo	rking	16b. Kind of Business	i/Industry
212	i within jiene. r then	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		ARCHITE			SHIPBUILD	TNG
ğ	if Hygin other	Be C	17. Father's Name (First, Middle, Last)			J ARROTTI CO		ne (First, Middle,	Maiden Sumame)	INO
lar		To B	JOSEPH WILSON				SARAH	E. GARVE	EY	
an	s 1 and 2 should f Health and Men fem 27 is marke other treumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
	and ealth m 27		MARGARET L. WILSON				k terrac		N, MD 2160	1
Ore	00-		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	1 00	ace of Dispo emetery, crer	sition (Name of matory or other place	θ)	Date	20c. Location - City o	r Town, State
Baltimore,	t. Partmen		4 □Donation 5 □Other (Specify)		1	KE CREMAT		1/17/200	7 STEVENS	VILLE, MD
Bal	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service License			P. Name and Addres		n & newn	AM FUNERAL	HOME PA
			23a. Part1. Enter the disease, or complic		2	10 S. HARI	RISON ST	EASTON,	MD 21601	Approximate
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.			. 1	or respiratory at	11651,	Interval Between Onset and Death
Ì	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	card	compop	athy			
Н	Examiner		1	2.1		+ Failure				
		Je.	Sequentially list conditions, if any, leading to immediate	Due of (or as a consequ	ience of):	anjure				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Acute tubi	ular	necros,	is of	Kidne	45	
ó	e exercien ar		resulting in death) Last	Due to (or as a consequ	ience of):				J-	
68760,	death certificate be executed e ettending physicien and d for use as the burial-transit	iclan/Medical	d.	Hra) O	ec.la	ten				
9 x	eath certific ettending pi for use as f	/Mec	IF FEMALE:	to 16 year automore of account						
Box	ettend for us	lan	in the past 12 months?	ic. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy			23d. Date of de Month	blivery Day Year
P.0.		Physic	1 Yes 2 No 9 Unknown	9□ Unknown	aui 5	Other (specify)				
	The law requires thet the de ate has been signed by the e page 2 should be detached i		Part II. Other significant conditions cont	ributing to death but not resu	ilting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	o the cause of death?
Records,	quires n sign ald be	Completed by	History of Hu	pentension				15	Yes 2□No 3□P	robably 4 Unknown
000	s been shoul	Siete	coman men	displace				24a. Was	an 24b. Were a	utopsy findings available
æ	The lav	E							osy prior to death? 2 No 1 Ye	completion of cause of s 2 No
Vital		Bec	25. Was case referred to medical				26. Place of Dea	1 Yes		5 2 140
of V	g is	ToE	examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 E	ER/Outpatier	nt 3□ DOA Othe	er: 4 ☐ Nursing H	lome 5 ☐ Resid	dence 6 ☐Other (Sp	ecify)
	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at k?	28d. Describe I	how injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>			Yes 2 □No			
Division	or Al	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str ')	eet, factory, office		28t. Location (3 City or To	Street and Number or F wn, State)	lural Route Number,
_	Hospitel 24 hours a Funeral tely filled		29a. Certifier 1/7 Certifying Phys.	ician: To the best of my know	wledge deat	n occurred at the tim	no, date and place	and due to the	anuso(s) and manner s	e stated
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2   Medical Examin	er: On the basis of examinati and manner stated.	ion and/or in	vestigation, in my of	pinion, death occi	rred at the time,	date and place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	/		29c. License	e number		29d. Date signed (Mor	th, Day, Year)
) ,		-	N. Sarul	,mn		Døg	15976	2	0y16/20	07
2			30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print)	1			333
/	5		Haide Son	ref, NO		505	ton, A	nr)		
		ate	31. Date filed (Month, Day, Year) JAN 18 2007	2. Registrar's Signat	ture	34				
DI	Regist	_			A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene [] [] 7

03061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#26. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 1542 PM Druille Danyay 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Baltimore Ut If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-23-1946 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Min Months 1 M 2 □ F 60 Director 219-42-8778 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medic - Examiner must be notifited at 1 XYes 2 □ No Funeral Director Baltimore Maryland Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Falcon Ridge Drive 21133 USA 8803 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 💢 Married Maryland 21215-0036 1 ☐ Yes 2 🕽 No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Morgan State Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) University Professor University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) uth and Mental h Be Wright 2 George E. Wright, Sr. Christine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8803 Falcon Dr., Randallstown, Maryland 21133 Gwendolyn Wright / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of Important; If any Injury or once. 4 □ Donation 5 □ Other (Specify) 01-13-2007 Chance, Maryland St. Charles Cem. <sup>22</sup> Name and Address of Facility Bennie Smith Funeral Home 524 Race Street, Cambridge, Maryland 21613 21. Signature of Funeral Service Licensee ammie Approximate Interval Between Onset and Death 28a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause with line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical donsequence of): Duo to for as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a nsequence of): Examiner law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the a 9 I Inknown 9 Unknown signed by t d be detach ignificant conditions ntributing to the but no esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 page certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient ER/Outpatient 3□ DOA P After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director; of the Funeral Director; of the formpletely filled in by the formpletely fille 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier,

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State Registrar Name and a

31. Date filed (Month, Day, Year) N

ress of p



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 19 2007 7:08 A January Michael Ric Walton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Howard County General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 12XM 2□ F Dec 19, 1940 Maryland 218 36 8557 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. Count 1 Yes 3 No Director MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 10075 Green Clover Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes. Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify White þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Building Materials Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augusta Fischer Ric Walton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10075 Green Clover Drive Ellicott City, MD 21042 Eleanor G. Walton/Wife 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Crest Lawn Mem. Gard. 1-24-2007 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 21. Signature of Funeral Service Licensee withen 4112 Old Columbia Pike Ellicott City, MD 21043 Allno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 24 hours Ventricular Tachycardia resulting in death) Due to (or as a consequence of): Ischemic Heart Disease 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Unknown Cardiomyopathy, Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 X No 1 Yes 2X No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2X No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760. detached P.O. Records, page 2 of Vital or Attanding Physician: ector. funeral Division death. I Diractor: A hours after within 24 hours a To the Funaral C

**Funeral** 

Director

rai', or items 23a or 28a-f ahow Examiner must be notified at

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item 27 is marked other than "natu other traumatic event, the Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked other any injury or other traumatic event pobes.

**Physician** 

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after

21215-0036

Baltimore, Maryland

31. Date filed (Month, Day, Year) JAN 2 2 2007

29b. Signature and title of certified

6



and manner stated

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

29c. License number

D46120

29d. Date signed (Month, Day, Year)

Jan 19, 2007

Medical (

State

Registrar

29a. Certifies (Check only one)

				State of Ma										03064		
		•	For State Registrar				ificate					Reg. No.	.00/	00001		
	Physicia	an -	Decedent's Name (First, Middle, Last)     Avant Oblee	Wi.	lliams						2. Date of Dea Month	Day	o 7	3. Time of Death  2300 M		
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, To	own, or	Location of	Death			ounty of Death			
	Zami		Peninsula legional	medical	Cente	,	50	1150	bury				licomi	10		
	Funeral Director		5. Social Security Number 6. Sex	(In yrs. last bin	thday) Yrs.	If Under 1 Months	Days	Hours	43	8. Date of Birt (Month, Da 1/16/	y, Year)		place (State or Foreign ntry) cyland			
			Usual Residence of Decedent						~	1		2007				
	arylan show	_	10a. State 10b. County		10c. City, Town									10d. Inside City Limits 1 □{\forall Yes 2 □ No		
	28a-f	Director	Maryland Wicomic  10e. Street and Number	:0	Sali	.sbur	10f. Zip 0	Code				10g. Citize	n of What Cou	ntry?		
	72 hours after death with the Maryland natural; or Items 23a or 28a-f show usal Examiner must be notified at		131F Mitchell Ro	ad	ad				21801				SA			
	death	Funeral	11. Marital Status	1 ☐Yes 2 X No			as Decede Yes, specif	ent of His	spanic Orig	in? (Spe Puerto I	cify Yes or No Rican, etc.)	- 14	. Race - Ameri Black, White,	etc.		
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215	within 7; ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	,		e retired,	uring most	OI WOIK!	,g					
121	filed withi Hygiene. other then ent. Ine M		n/a 17. Father's Name (First, Middle, Last)	n/a		n/a	<u>a</u>		18. Mothe	r's Name	(First, Middle,	n/ Maiden S				
and	d be featal h	To Be	Sherron Oblee Wil	liams							Rones					
Maryland	2 should be and Mental is marked of sumatic svi	۲	19a. Informant's Name/Relationship (Ty		19b								Town, State, Zi	p Code)		
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural; or Items 23a or 28a-1 show or other fraumatic event. The Marical Examiner mast be notified at		Jaynesha R. Jones	s/mother	20h Place o		almost and a second				lisbur		ation - City or T	own State		
Baltimore,	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ F	Removal from State	20b. Place o cemete					1/19			isbury			
	그 문문을 .		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>	0	Salis		•		-							
B	Depa Impo any ii		21. Signature of Fungral Service Licensee  22. Holly of Fungral Service Licensee  22. Holly of Fungral Home Professional Associate  501. Snow Hill Rd., Salisbury, ND 21804													
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68	ificate g phys as the			0												
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	w requires that the death certificate been signed by the attending phy should be detached for use as the	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 🗌	Other (spe	ecify)								
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			State Registrar	Reg. No. UU/ 03065										
П	Physici	an	1. Decedent's Name (First, Middle, Last	)	Date of Death     Month		Year	3. Time of Death						
	/Medic	al	James Luther Your 4a. Facility Name (If not institution, give			4b City Town o	r Location of Dea	January	22, 20 4c. County o		6:42 A M			
	Examin	er	10824 Downsville B	· ·	uı	Washi		an.						
ī	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days		. (Month, Day,	Year)	9. Birthp	lace (State or Foreign			
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	death	nera	11. Marital Status	12. Was Decedent Ever	in U.S. 13.		lispanic Origin? (S	Specify Yes or No- rto Rican, etc.)	14. Race		an Indian,			
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 25 No If Yes, Give		irYes, specify Cuba 1□Yes 2ሺŽNo	an, Mexican, Puei Specify:	no Hican, etc.)	Specify:	, White, e				
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89 x	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		23d Date	te of delivery								
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<u>ta</u>		Be C	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 ☑ No						
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במ	nding Physicien: th. : After this certifica funeral director, p	tion:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	Wor	yat k? Yes 2. □No	28d. Describe how injury occurred						
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	To th within To th compl	Me	29b. Signature and title of certifier	1 \		29c. Licens		_	d. Date signed					
			Mouten He	ih M. D.		0560	148	J	January 23, 2007					
	10		30. Name and address of person who c	·1 . J. 11	(Item 23a) (Type,	Print) any land	21750							
	Sta	ite	31. Date filed (Meath Day Yagr)	32. Registrar's	COCIC, III	48. 5								
E	Regist	rar	LED A & SON	CHEST VIEW	N. Salan	-8-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 Amend item 1- State Ragistrar #26 per DR/wichd/1-19-07/dls Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Francis Zimmerman Jr. Joseph 8:30 January 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Mardela Springs 10985 Riverton Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/12/1955 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1**M**M 2□F Maryland 217-68-4096 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Mardela Springs Director Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21837 10985 Riverton Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify. white by Navv 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance 12 Insurance Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Leuschner Joseph Francis Zimmerman Sr. 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10985 Riverton Rd., Mardela Springs, MD 21837 Brenda Zimmerman/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 N Cremation 3 Removal from State Salisbury Crematory Salisbury, MD 4 □Donation 5 □ Other (Specify) 1/17/07 21. Signature of Funeral Service Ligenses Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metestatic **Physician** and /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ete has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 DNo 1 Yes 2 X No To the Hospital or Attanding Physicien: 25. Was case referred to medical examiner?
1 Yes No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA ဥ this 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Natural 2 Accident 5 Pending investigation after death. 1 □ Yes 2 □ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Momicide 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

within 2

and manner stated

rson who completed cause of death (Item 23a) (Type, Print)

Coest-1

32. Registrar's Signature

ORIGINAL

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Bux 1733 Solish MD

29d. Date signed (Month, Day, Year)

21802

			For State Registrar	State of Ma		tificate of I			ig. No.	/ 0303/				
			1. Decedent's Name (First, Middle, Last)  2. Date of Death North Day Year											
	Physicia /Medic		Reza		I	Azarbal		Ŏ1	21 20					
7	Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death		4c. County of D	Peath				
			Howard Co. Ger	eral Hos	pital		lumbia		How					
	Funeral		Social Security Number     6. S	9x 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)				
	Director		5//-62-4/64	UM ZUF	75 Yrs.	,		01 06	32	Iran				
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yland 21215-0036	aryla eho	5	MD Howa	53	Columb					1 ☐ Yes 2X No				
	Ne N	ect	10e. Street and Number	i E u	COTUM	10f. Zip Code		11	Og. Citizen of What	Citizen of What Country?				
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	9eth	Funeral Director	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13.1			pecify Yes or No-		American Indian,				
	Her d	Ę	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 23 N	lo.		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Vhite, etc.				
36	irs at	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes X⁄⊡No	Specify:		Specify:	White				
ğ	2 hou	pel	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occup	pation	1./	16b. Kind of Busine	ess/Industry				
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Baltimore, Maryland 21215-0036	and l		19a. Informant's Name/Relationship (			•			City or Town, Star					
	and and n 27		Jean Bahram Aza	arbal-Son						, Md 21045				
Sec	of Herr		20a. Method of Disposition	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other plac	сө)		20c. Location - City					
Ĕ	Pag ment ant: i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	King Me	morial	Park 1/	24/07	Randall	stown, Md				
alt	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturet", or Iteme 23a or 28e-f show withing yor other traumatic event, the Mudical Exam let must be multiped at QDCs.		21. Signature of Funeral Service Licer	isee	M	arch F/	H West			01015				
_	20599		aneth 1	- Ine	.) 43	00 Waba	sh Ave,							
/M			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between				
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):									
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		Medical	(Check only Amadical Exa	minar: On the basis o and manner st	f examination and/or in	vestigation, in my o	opinion, death occu	irred at the time, d	ate and place, and	due to the cause(s)				
	within 2 To the	Me	29b. Signature and title of certifier	1, 10		29c, Licens	se number	00 2	9d. De e signed	th Day, Year)				
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1	2		30. Name and address of person who	mpleted cause of c	leat Item 23a) (Type,	Print)	110	-1.	$\mathcal{D}$	Elly of I				
<u></u>			Melvin of Cos	rden M	1) 950	0100	on Hub	vapolis	. Koas	CityM				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician DOROTHY ALSTON EMILY 2007 1715p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1030 E. 33rd Street Apt. 107 Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 217-20-6061 Yrs Md. 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Department of Health and Mental Hygiene. Introducing them 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. once. 1XYes 2□No Director Baltimore Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1030 E. 33rd Street Apt. 107 21218 Pages 1 and 2 should be filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: þ Black 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Delivery 9th grade Baltimore Sunpaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pryor Robinson Emily ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Niece 4304 Kenwood Avenue, Baltimore, Md. Marion Church-Frazier 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danation 5 ☐ Other (Specify) 2-6-07 Owings Mills, Md. Garrison Forest Vet. 🖯 Signature of Funeral Service Licer 22. Name and Address of Facility March F.H. East 1101 E. North Avenue, Baltimore, Md. 21202 2 A. Parti. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. leath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death mmediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARDIO MYO PATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate ha 2 12 No 1∐ Yes the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Praesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 📈 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0272 TANUARY 26, 2007 meles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 204 BARTIMORE, MOZIZZY S. MILLEN 724 MAIDEN CHOICE CANE

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 35 A M HRGARET HTVDERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖸 F Yrs 215-05-1072 Director 88 21,1918 Delaware April Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 9 Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Posta1 Postmistress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene J. Kilduff Margaret Nowland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances K. Justice Sister 10121 Donleigh Drive; Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 4 □ Donation 5 □ Other (Specify) 2/8/2007 Baltimore, Maryland 22. Name and Address of FacilitSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumon,9 Immediate Cause (Final **Physician** 100 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) March Choice 900 C9215

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

gistrar's Signature

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

State Registrar

ALI, M.D. Sinai MAHAJABIN 31. Date filed (Month, Day, Year) FEB 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

Hospital

Baltimore,

2401 West Belvedere Baltimore Mariland

Etimore, Maryland 21215

		For State Registrar		5	State o	of Mary	/land /				ealth a Death	nd M	lental l		ene []	07	0307	
		Decedent's Name (Fig. 1)	rst, Middl	e, Last)									2. Date of				3. Time of Death	
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Examir		4a. Facility Name (If not							4b. City,	Town, or	Location of	f Death			4c. County			
		119 Charge		oad							stown				Ва	ltim	ore	
Funeral		5. Social Security Numb	er	6. Sex	1 2 F	1	n yrs. last b		If Unde Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of (Month	Day, 1	rear)	9. Birth	place (State or Foreig	
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land w		Usual Residence of Dec 10a. State 108	b. County	,		10	Oc. City, To	wn or Lo	cation								10d. Inside City Limit	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itema 23a or 28a-f show eny Injury or other treumatic event, I're Modical Examination in collision at an analysis.	١٥	MD	D - 1 +	imore			D	iat-									1 ☐ Yes 2√∑ N	
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me 2	Funeral	119 Chargeur Road  11. Marital Status   12. Was Decedent Ever in U.S.   13. Wa							21136 Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican,					es or No- 14. Race - A				
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d2s Ith an I7 is I		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)																
Heat Heat tem 2		Patricia L. August Wife 119 Chargeur Road, Reisterstown, MD 21136  20a. Method of Disposition   20b. Place of Disposition (Name of Date   20c. Location - City or Town, State																
ages int of t: If It		1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)																
nit. P entme ontan Injury		4 □Donation 5 □Other (Specify) Evergreen Mem. Gardens 2/3/07 Finksburg, MD  21. Sign for of Funeral Service Censes 2. Name and Address of Facility 11824 Reisterstown Road																
Depending of the policy of the		the same	K	0							eral :				erstov			
		23a. Part1. Enter the d	isease, or	r complica	itions that	caused the	e death. Do										Approximate Interval Between	
Medical Examiner Asicien end e burial-transit	dical Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):																
The law requires that the death certificate be executed ate hes been signed by the attending physicien end page 2 should be detached for use as the burial-transit	Completed by Physician/Medio											I. Date of delivery Month Day Year						
equires that an signed ould be de	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions to the underlying cause given in Part I.									tnbute to	1						
reiclen: The law re s certificate hes be lirector, page 2 sho	Complet	24a.									Vas an utopsy enforme	24b. Were autopsy findings available prior to completion of cause of death? 2No 1 9 9 2 No						
clan: ertific	Be	25. Was case referred examiner?	to medica							7		of Deat	h (Check o	nly one	)			
ding Physi h. After this c funeral dire	tlon; To		Pendir			Inpatient of Injury of, Day Ye	2 🗌 ER/0 28b ea <i>r)</i>	Outpatien  Time of Injury		28c. Injury Work	and the same			Presidence 6 Other (Specify) cribe how injury occurred				
To the Hospital or Attending Physician: within 24 hours after death. (To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification;	2 Accident 3 Suicide 6 4 Homicide	Could determ	not be	28e. Plac build	e of Injury ting, etc. (3	- At home, Specify)	farm, str					28f. Locati City or	on (Stre Town,	et and Num. State)	ber or Ru	ral Route Number,	
the Hospi in 24 hour the Funer pletely fills	edical	(Check only 2 one)	Gertifyii Medical	ng Physic Examine	r: On the	basis of ex nner stated	amination i	ige, dean and/or in	estigation	at the time, in my op	oinion, deat	h occur	and due to red at the ti	the cau	te and place,	anner as and due	stated. to the cause(s)	
To t	Σ	29b. Signature and title	of certifie	er J					29	c. License	number	(2		29	d. Date signe	ed (Month	, Day, Year)	
77	3	29b. Signature and title 29b. Signature and title 30. Name and address 31. Date filed (Month, E	of person	A who com	plet of cau	, M.	h (Item 23a	a) (Type,	Print)	υ D.	P.t.	# 7	40	0.	2/1	he. 1	12 wd	
1		Howard J	2134	TZ M	· D .	23	Cros	300	44	V L.	J/~			- L	7	1. /	- 46 21	
Sta Regist	ate rar	31. Date filed (Month, E	jay, Year, EB 0	5 20	07 32.	registrar's	Signature	A fa	back	P								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MILEn 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner g. Birthplace (State or Foreign Country) mare 8. Date of Birth (Month, Day, 5. Social Security Number (In ws. last birthday) **Funeral** Year) Months Min 1 □ M 2 X F 24-1930 Baltimore, Mi Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10c. City, Town or Location 1 □ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in Funeral Was Decedent Ev. Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21**X**No Baltimore, Maryland 21215-0036 1 ☐ Yes Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Uwings Mills, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VQ u( MO 140 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm ate Cause (Final **Physician** disease or condition resulting in death) Due to for as a consequence of): /Medical Examiner Duy to (or as a consiquence of Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending philor use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9☐ Unknown 9 ☐ Unknow/ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division or Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1□ Yes 2 No ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: spital: 1 Inpatient 28a. Date of Injury 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 □ DOA မ funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

	1	For State of M	laryland / Depar	rtment of He			2 H H / H K H / K
Physicia /Medica Examine	n ii -	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not jinstitution, give street and number)	119	4b. City, Town, or L	2. Date Mon	V. 31	3. Time of Death
Funeral Director		5. Social Security Number 6. Sex 7. A		BA DIII If Under 1 Year Months Days	If Under 24 Hrs. 8. Date (Mo	e of Birth nth, Day, Year)	9. Birthplace (State or Foreign South Canking
5-0036 72 hours after death with the Maryland retural", or items 23a or 23a-f show dical Examiner must be notified at	al Director	10a. State 10b. County  NA  10e. Street and Number  10B A 92017 15 9	10c. City, Town or Loca  PATIN	10f. Zip Code	29	10g. Citi.	10d. Inside City Limits 1 ☐ Yes 2 ☐ No  zen of What Country?
Iltimore, Maryland 21215-0036 nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education	No 1941- 16a, Decede	Yes 200 No	panic Origin? (Specify Ye , Mexican, Puerto Rican, e Specify:	etc.)	14. Race - American Indian, Black, White, etc.  Specify: DAW  nd of Business/Industry
and 21215-0036 be filed within 72 hours af Ital Hygiene. ed other than "natural", or event, the Medical Exa <u>mi</u>	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40)  17. Father's Name (First, Middle, Last)	· 5+) (Give ki	155/ V	Iring most of working  OR VER  18. Mother's Name (First,	Middle, Maiden	Surname)
ore, Maryland ss 1 and 2 should be file of Health and Mental Hy ltem 27 is marked oth other traumatic event	<u></u>	19a. Informant's Name/Relationship (Type. Print)  DAUGHT 20a. Method of Disposition	20b. Place of Disposi	3 N. G	nd Number or Bural Route	37 PAL	or Town, State, Zip Code)  J. M. D. J.
Baltimore, permit. Pages 1 a Department of Hec Important: If Item any Injury or othe		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of uneral Service In see	* LOUNDON	Park PARY PM	J-7-0 SHIVIEW PA	7 PANTE	History MD
Physician /Medical Examiner		Due to (or a	ed the death. Do not enter line.  STATIC CAN as a consequence of):	/		atory arrest,	Approximate Interval Between Onset and Death  3 MONTHS
760, to be executed ysician and le burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	as a consequence of):				
Box 68 sath certifica attending ph for use as th	Physician/Medi		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)		:	23d. Date of delivery Month Day Year
Records, P.O. he law requires that the de e has been signed by the a	Completed by Pt	Part II. Other significant conditions contributing to death	but not resulting in the unc	derlying cause give			use contribute to the cause of death?  SNo 3 □ Probably 4 □ Unknown  24b. Were autopsy findings available
Vital	To Be Comp	25. Was case referred to medical examiner?  1 □ Yes 2 № No	atient 2 □ ER/Outpatient	3∏ DOA Othe	26. Place of Death (Chec		prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Division C or Attending P after death. Director: After t in by the funera	Certification: T	27. Manner of Death  1 KNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of investigation 28e.		28c. Injury Work M 1 \( \sup Y	at ? 28d. De? /es 2 □ No 28f. Loc	scribe how injur	ry occurred and Number or Rural Route Number,
To the Hospital Within 24 hours a To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1  Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination and/or inve	estigation, in my op	pinion, death occurred at the	ne time, date and	d place, and due to the cause(s)
To T Com	2	29b. Signature and title of certifier  Concadhracy		29c. License			te signed (Month, Day, Year)
Uhy		30. Name and address of person who completed cause of BALTIMORE VAMC LON.	GREENE ST		MORE, MD	2/20/	1
Sta Registra		31. Date filed (Month, Day, Year) \$2. Reging FEB 0 5 2007	strar's Signature				

Privision   Priv	
Provided   Part   Par	07 09,55 AM
Foneral Director  Fineral Dire	
Director	eath
Special and property   Secondary   Secon	Birthplace (State or Foreign Country) UShington, DC
Special and property   Secondary   Secon	10d. Inside City Limits 12 4es 2 □ No
Special and property   Secondary   Secon	Country?
Special and property   Secondary   Secon	
Special and property   Secondary   Secon	Merican Indian, Vhite, etc. Black
State   Stat	ess/Industry
192. Informant's Name/Relationship (Type, Print)  194. Mailing Address (Sineal and Namer Route Nowellia Som Plane and Disposition 194. Informant's Name/Relationship (Type, Print)  195. Mailing Address (Sineal and Namer Route Nowellia Som Namer Route Namer Route Nowellia Som Namer Route N	ation
This A Anderson - Sister 44 38 Baynal Tr. Wallacity Managery 1 20a. Method of Disposition 1 (Name of cemetry, cemanory or other place) 1 (Name of cemetry, cemanory or other place) 20a. Method of Disposition 1 (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry) 20b. Place of Disposition (Name of cemetry) 20b. Place of Disposition (Name of cemetry, cemanory or other place) 20b. Place of Disposition (Name of cemetry) 20b. Place of Disposition (Name of c	
1   Sequentially list conditions of any leading to immediate Cause (final desars) of any leading to any l	D 20 602
21. Signatural of Funeral Service Licensee  22. Signatural of Funeral Service Licensee  23. Name and Address of Facility  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23a. Fart I failure. List only one cause on each line.  23b. Fart I failure. List only one cause on each line.  23c. Fart I failure. List only one cause on each line.  23d. Date one cause. Line I failure. List only one cause on each line.  23d. Date one cause. Line I failure. List only one cause on each line.  23d. Date one cause. Line I failure. List on	or Town, State
Physician /Medical Examiner  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Immediate Cause (Final disease or coach on resulting in death)  25. Examiner  26. Place of Death (Check only one)  27. Was case referred to medical examiner?  28a. Part. Enter Underlying Cause (pissase or injuny that initiated events resulting in death) Last  29a. Part. Enter Underlying Cause (pissase or injuny that initiated events resulting in death) Last  29b. Was decedent pregnant in the past 12 months?  1	over, MP
Physician /Medical Examiner  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as	Approximate
Due to (or as a consequence of):    Due to (or as a consequence of):	Interval Between Onset and Death
Due to (or as a consequence of):    Secondary   Second	1 12hours
TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   Y	luear
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   9   Unknown   23d. Date of Month   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   2   Month   2   Environmental   2   Environmenta	6 years
The state of the s	delivery
25. Was case referred to medical examiner?  1	Day Year
25. Was case referred to medical examiner?  1	e to the cause of death? ] Probably √ 4 ☐Unknown
25. Was case referred to medical examiner?  1	autopsy findings available
25. Was case referred to medical examiner?  1	to completion of cause of 1? Yes 2 No
The second of th	
D E E E E D D D D D D D D D D D D D D D	ipecity)
27. Manner of Death   Statural   2   Accident   3   Suicide   4   Homicide   4   Homicide   5   Place of Injury - At home, farm, street, factory, office   28d. Describe how injury occurred   28d. Describe how i	
27. Manner of Death 1 Statural 2   Accident 3   Suicide 4   Homicide  28a. Date of Injury M   1   Yes 2   No  28c. Injury al Work? 1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  1   Yes 2   No  28d. Describe how injury occurred  28d. Describ	
29b. Signature and title of certifier 29c. License number 29d. Date signed (I	r Rural Route Number,
Channing Faller, Medical Doctor RES-000 January	r Rural Route Number,  r as stated, due to the cause(s)  onth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Channing Paller, The Johns Hopkins Hospital, 600 North Wolfe Street. Man	r Rural Route Number,  r as stated, due to the cause(s)  onth, Day, Year)
State  State  31. Date filed (Month, Day, Year)  Senistrar  Senistrar	r Rural Route Number, r as stated. due to the cause(s)

				artment of Health and Me	ntal Hygiene	03075		
I	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  LUCILLE BORTOLUZ	2 [	Date of Death  Month Day Year  Pebruary 2, 2	3. Time of Death 007 9:00P M		
	Examin		4a. Facility Name (If not institution, give street and number) Genisis Catonsville Commons	4b. City, Town, or Location of Death Catonsville	4c. County of Dea Balti	Baltimore		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 179 05 5365 1 M 2X F 86 Yrs.	If Under 1 Year   If Under 24 Hrs. 8   Months   Days   Hours   Min.   F		nthplace (State or Foreign country) ennsylvania		
	Maryland -f show lied at	tor	10a. State 10b. County 10c. City, Town or L	ocation idalk		10d. Inside City Limits 1 ☐ Yes 2 ☒No		
	h with the 23s or 28s st be noti	Funeral Director	10e. Street and Number 103 Center Place Apt. 122	10f. Zip Code 21222	10g. Citizen of What C	ountry?		
980	d within 72 hours after death with the Maryland Jione I than "naturel", or Itams 23a or 28a-f show I're Madical Examiner must be natified at	by	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ric				
21215-0036	d within piene. r than	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) Clerk	16b. Kind of Business Social Se	•		
Maryland	be d b	To Be C	17. Father's Name (First, Middle, Last) Walter Andrewsky	18. Mother's Name (F Mary S	First, Middle, Maiden Sumame) emczyk			
, Mar	nd 2 sh alth and 27 is m r treum		Patricia Klump (Niece) 3203-	ing Address (Street and Number or Rural F -15 Lenox Rd. Atlant	a, Georgia 3032			
altimore,	Page nent c ant: if ury or	1	'4 □ Donation 5 □ Other (Specify)  Bayview	Crematory 2/3/20	07 Baltimore,			
Ba	Departi Departi Importa any inju		HOTWI IV. DURKWEELE	2. Name and Address of Facility Bruzdzinski Funeral 407 Old Fastern Ave	nue Essex, Maryl			
	Physician /Medical Examiner		23a. Faft. Enter the disease, or complications that caused the death. Do not enstroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death		
8760,	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):					
O. Box 6	death certific e attending pl ed for use as t	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	olivery Day Year		
<u>α</u>	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to	o the cause of death?		
Vital Records,	The ate h page	Completed	Cerebrovessuler Di	eere.	24a. Was an autopsy performed? 1 Yes 2 100 1 Yes	utopsy findings available completion of cause of		
of Vit	Phys this al dir	To Be	25. Was case referred to medical examiner?  1 Yes 2 1000  Hospital: 1 Inpatient 2 EP/Outpatie  27. Mannes of Death  28a. Date of Injury 28b. Time		5 ☐ Residence 6 ☐ Other (Spe	ecify)		
Division	fter	Certification;	27. Mannas of Death  1	Work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred     Location (Street and Number or R     City or Town, State)	ural Route Number,		
Ω	Hospital 4 hours Funerel ely filled	edicai Cel	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal can be dea	th occurred at the time, date and place, and vestigation, in my opinion, death occurred	due to the cause(s) and manner at the time, date and place, and due	s stated. e to the cause(s)		
)	To the within 2 To the complet	Med	29h Signature and title of certifier Atte	7 29c. License number D 3 6 9 4 2	29d. Date signed (Mont	3, 2007		
1	٧		30. Name and address of person who completed cause of death (Item 23a) (Type of TORAKNIA M) 1009, Fre	David Ra Caterry	ville, mp 2/2	228		
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 0 5 2007  32. Registrar's Signature	antis				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City. Town, or Location of Death

3. Time of Death

РМ

2215

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 X Yes 2 No

29115

Approximate Interval Between Onset and Death

ear

Year

Reg. No.

January 26, 2007

4c. County of Death

USA

Prince George's

SC

14. Race - American Indian,

Black, White, etc.

Specify: Black

23d. Date of delivery

Month

Queensbury Rd Hyattsville MD 20781

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 \( \text{No}

3 Probably 4 Unknown

2. Date of Death

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Η.

4a. Facility Name (If not institution, give street and number)

Hamilton

Boyd

Thomas

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month Day Year)

of death (Item 23a) (Type, Print)

07-00745 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Elizabeth Banks State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ Date of Death 3. Time of Death Month Day January 26, 2007 Medical Examiner 1316 hrs 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Dear 2803 Lauretta Ave Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or Months Days Hours Foreign Director М Georgia Usual Residence of Decedent Town or Location City. 10d, inside City Limits 28a-f show 1 X Yes 2 No hours after death with the Maryland Director 10e. Street and Numbe 10g. Citizen of What Country' Funeral 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 9 If Yes, Give Year Divorced 1 Yes 2 No specify item 27 is marked other than "natural", reaumatic event, the Medical Examiner \$ 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene ant: If item 27 is marked other than "r or other traumatic event, the Medical E Baltimore, MD 21215-0036 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 2 Cremation 3 crematory or other place) Burial Removal from State Important: Donation 5 Other Specify Signature of Funeral Service Licep caused the death. Do not enter Physician Approximate Interval failure. List hely one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Hypothermia complicating atherosclerotic cardiovascular discuss Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and or use as the burial - trai Physician/Medical X UNPENDED ,28a-f, perME Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ð Yes 2 V No 3 Probably 4 Completed certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifi 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> DOA Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 X No Fnd 1/26/2007 Fnd 2:00 pm found in cold environment 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) Homicide roadway 2803 Lauretta Ave. Baltimore, MD 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E January 27, 2007

Margarita Korell MD.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registra's Signature

30. Name and ad ress of person who completed cause of death (Item 23a)

P 0 5 2007

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O 2 **Physician** 40 03 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex rs. last birthday) f Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 245-38-4039 North Carolina Director July 20,1929 Usual Residence of Decedent death with the Maryland or 28a-f show a notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No N/A Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or Items 23a or Examiner must be r 2711 Woodsdale Avenue 21214 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specif White Specify: Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Assembly Line Worker Lever Brothers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James P. Guffey Eda Jane Brackett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel Mantegna Son 2711 Woodsdale Avenue, Baltimore, MD. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Baltimore City, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Day Year 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Inknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signa end title of certifier 29d. Date signed (Month, Day, Year) O 01 toch Paven Blud

State Registrar

30. Name

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

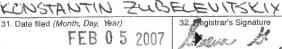
32. Registrar's Signature

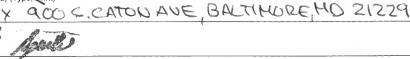
State

Registrar

31. Date filed (Month, Day, Year) FEB 05 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





JAN 27, 2007

			For State Registrar		State of	f Marylan	-	artmen tificat					jiene leg. No.	2007	03	3080
	Physici	an	1. Decedent's Name (First, A	liddle, Last)								. Date of Dea Month	Day	Year		e of Death
	/Medic	al	Lewis G. Bige 4a. Facility Name (If not insti		reet and nun	nher)		4b City	Town or	Location		anuary		2007 County of De		5 AM M
	Examin	er	2 Cardinal L	-	, 00, 2.0			,,	Ess					Balt	imore	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under		If Under	24 Hrs. 8	. Date of Birth (Month, Day	(Year)		Country)	ate or Foreign
- 1	Director		118-22-5482		M 2□F	7.7	Yrs.	WORKITS	04/5	1100.0		uly 25	, 19	929 N	ew Ýor	k
	pur *		Usuel Residence of Deceder 10a, State 10b, Co			10c. Cit	ty, Town or Lo	cation							10d. Insid	le City Limits
	Aaryli I sho	ö		1timor	•			ssex							10	Yes 2 No
	the h	rect	MD Ba	LLIMOI	e		E	10f. Zip	Code				10g. Citi	zen of What (	Country?	
	72 hours after death with the Maryland "naturel", or items 23a or 28a-f show	Funeral Director	2 Cardinal	Lane					21	221				USA		
	death rms 2	nera	11. Marital Status	1	2. Was Dece Armed Fo	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	ispanic O	rigin? (Specif	fy Yes or No- can, etc.)		14. Race - An Black, Wh		n,
ဖွ	ĕ ≛ 5	/ Fu	1 Never Married 2		1 ☐ Yes If Yes, Giv	2 📉 No		1 ☐ Yes		Specify		3411, 010.7			white	
003	hould be lied within 72 hours after and Mental Hygiene. marked other then "naturel", or its matic event, the Medical Examina	d by	3		Year or Da	ates:						-	101 10			
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d 2	Hygi Hygi ent, I		17. Father's Name (First, Min	idle, Last)	U		·	Cust	m cc		er's Name (i	First, Middle,			ETECLI	unk
<u>e</u>	Mental Mental arked c	To Be	Lewis G. B:	igelow	Sr											
Maryland 21215-0036	" = = 3	-	19a. Informant's Name/Rela					•						r Town, State	, Zip Code)	
	s 1 and 2 should be littled within the Haith and Mental Hygiene. Item 27 is marked other then other treumatic event, the Market		Yvonne O'Ne	eil/da	ughter		_ frame soons			ine E	ssex,		1221			
Baltimore	permit Pages 1 and 2 Department of Health a Importent: If item 27 is any in ury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 💆 Oth			State	Place of Dispo cemetery, crei	esition (Nai matory or d	ne of ther plac	e)	Dat	e	20c. Lo	cation - City	or Town, Stat	:0
Ball.	permit Departir Importany in u		21. Signature of Funeral ROII	yice Eicense	ade, I	irecto				-	Board 2120		. Ва	ltimor	e Str	eet
			23a. Part. Enter the disease shock or heart failure.	e, or complice	ations that c	aused the deal	th. Do not en	er the mod	e of dyin	g, such a	s cardiac or r	espiratory ar	rest,			l Between
	Physician		Immediate Cause (Final disease or condition		1 / / )	OSTA	7E (	An	LE	R					Onset	and Death
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2		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>J</b> °	Due to	(or as a consec		it's		0	NE				19	29
7 %	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	О.	101/		VER S	> "	NIZ	1001	NE				1 1	0 1
2 per	te be exe sysicien a	E	resulting in death) cast		Due to	(or as a consec	Q	IZVIS	00						10	106
587	• 9 × 9	dicai		d.	1	110	( )									
Sox 6	The law requires that the death certificate has been signed by the ettending phage 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnal	nt 23		tcome of pregn		7						23d. Date of c	lelivery	
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	ires tha signed d be del	by F	Part II. Other significant co	nditions con	tributing to d	eath but not res	sulting in the u	inderlying o	ause giv	en in Part	I,		_	ise contribute		
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ن <sup>ي</sup> د ا	ysician: The li is certificate ha director, page 3	Be	25. Was case referred to me examiner?	_	ospital:				Oth			Check only o				
7 J	Phys this	5.	1 Yes PNo 27. Manner Death		1		28b. Time o		JA	401	lursing Home	d. Describe h		6 □Other (S) v occurred	oecify)	
the	Afte fune	tlon	Natural 5 □ P	ending vestigation	(Mon	of Injury th, Day Year)	Injury	м	28c. Injun Wor 1 🔲	k? Yes 2[						
Fay to	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certificately filled in by the funeral director.	ertifica	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place build	of fnjury - At h ing, etc. (Speci	nome, farm, st	reet, factor	y, office		28	if. Location (S City or Tox	Street an vn, State	d Number or	Rural Route	Number,
		Medical Certification:			ar: On the b	e best of my kn easis of examination stated.										use(s)
_	To the Within 2 To the comple	Me	29b. Signature and title of c	ertifier	i	1 /	1	29	c. Licens	e number	0		29d. Da	te signed (Mo	nth, Day, Ye	ar)
	. 21 0		Schail	18)	sta	ta (	Van	les	1)	-4	80.	25	1 -	-28	-0	
			30 Name and address of po	erson who co	mpleted cau	e of death (Ite	om/23a) (Type	Print)	221	10	ItES	Aco	A	VÉ,	BALT.	J, MD
	St	ate	31. Date filed (Month, Day,	Year) 5 2007	32. F	Registrar's Sign	nature /	The state of the s							21	237

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** BROWN MACK 0540 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BATTIMORG NIA UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 5-28-2839 Days Hours Jan. 12 Carolina Director North Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Kes 2 No Director Md 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Ves 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1452 altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 3 ☐ Widowed 4 Divorced 1958 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (Eirst, Middle, Last) Be Lown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tom Rd. Balto. md. roster 332 tamela daughter 2/22 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Conation S Other (Specify) -07 OWIND MILLS 21. Signature of uneral-Service License MM 23a. Part1. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EPSIS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mount page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one)

State Registrar

29b. Signature and title of certifier

DR ODIGIE

31. Date filed (Month, Day, Year)

FEB 0 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE

29c. License number

BATTIMORE,

1744

29d. Date signed (Month, Day, Year)

2007

07-00804 Willa Me

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ard F Chaffn		1- For State Registrar				ent of Heal ate of Deat	th and Mental I <i>h</i>		Reg. No.	200	17 0208
Physicia dical Exami		1. Decedent's Nam	ne (First, Middle,Las	f) F •		Cha	ffman	2. Date of D Month	eath Day 29, 2007	Year	3. Time of Death
			(if not institution, giv		)		T T III a I I  Fown, or Location of Dea			ounty of Deat	l
	Н		wwood Ave., A			Baltir		· la p · · ·			
Funeral Director		5. Social Security 216-05-	1 _	7. Ag	ge (In yrs. last bir		er 1 Year If Under 24h is Days Hours M	lin.	Birth(MM/DD	Forei	rthplace (State or gn puntry) MD
any		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Town	or Location					10d. Inside City Limits
<u> </u>	٦	MD	NA		Bal	timore					1X Yes 2 No
Maryla 28a-f d at ou	Director	10e. Street and No				10f. Zip	Code		10g. Citizer	of What Cou	ntry?
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eath wi	Funeral	<ol> <li>Marital Status</li> <li>Never Marr</li> </ol>	ried 2 Married	12. Was Deceden	?		ent of Hispanic Ongin? ( fy Cuban, Mexican, Pue		No-   14	White, etc.	rican Indian, Black,
after de	by Fu	3 XWidowed	4 Divorced	1 Yes 2	No No	1 Yes 2	X No specify:		Sp		ite <del>Clack</del>
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5-0036 iled within 7. Hygiene.			e (First, Middle, Last		L			me (First, Middl			724 1106025
121 Id be fi 1ental I narked event,	Be c		in Chafi		1 40	lb B4-11/- Addres	Maude (Street and Number of				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I filem 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once	To		undy-Go				eld Road,				
re, l I and F Healt Fitem er tran		20a. Method of Dis			20b. Place	of Disposition (Na tory or other place	me of cemetery,	Date		cation - City o	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5	Other Specify	:	LLIC	land Me	morial 2/	2/07	Par	kvill	le, Md
Baltimo permit. Page Department of Important: injury or off		21. Signature of F	uneral Service Licer	<b> </b>	CM	March	Address of Facility F/H West				
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		or condition result	h	Due to (or as a cons	sequence of):						
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). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	Medical E	UNPENDE	d. <b>X</b>	AMENDED 14	per fh	g864 2-5	i-07 vt			-	
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ires that the designed by the signed for	by	Diabetes I	nificant conditions Mellitus	contributing to dea	ith but not resulting	ng in the underlyin	g cause given in Part I.				o the cause of death?
ords, w require ts been si should b	eted							24a. W			utopsy findings available
Records, P.C. The law requires that cate has been signed by	Completed							pe	topsy rformed? s 2 V N	death?	completion of cause of 'es 2 No
	a)	25. Was case refe examiner?	erred to medical				26 Place of Death (Che		3 2 1		65 2 10
F Vit Physici rrthis c	To B	1 Yes	2 No			-		rsing Home 5		e 6 🗸 Othe	er: Scene
on of Vital I rending Physician: eath. or: After this certifi the funeral director,	ion:	27. Manner of Dea	5 Pending	28a. Date of In (Month, Day)	jury 28b. Year)	Time of Injury	28c. Injury at Work?  1 Yes 2 No	28d. Descri	be how injury	occurred	
S = 5 = 5	ficat	2 Accident 3 Suicide	Investigat  6 Could not	28e Place of I	Injury - At home,	farm, street, factor	y, office building, etc.			Number or R	ural Route Number, City
ie Se in	Certification:	4 Homicide	determine					or Towi	n, State)		
To the Hos within 24 h To the Fun	Medical (	29a. Certifier (Check only one)			amination and/or		e time, date and place, a ly opinion, death occurre				
F % F S	Me	29b. Signature an	d title of certifier	$\wedge$		29	c. License number				onth, Day, Year)
4		( ) (	Sorle	u()			O.C.M.E.		Janua	ary 30, 200	·/
1		30. Name and add	dress of person who ce MD. Assis	completed cause of tant Medical Ex			t, Baltimore, MD 2	1201			
		31. Date filed (Mo		E/	ar's Signature	Scools					
Regis	uel		EB 0 5 20	107 Store	in S.S.	fre to the state of the state o					

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-00811 Michael S. Catlett State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 29, 2007 1400 hrs Medical Examiner Catlett Steven Michael 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 1616 Heathfield Avenue If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Months Davs Hours 62 MD Director 10 04 44 213-80-3889 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10b. County iny 1 X Yes 2 No Baltimore items 23a or 28a-f show ust be notified at once. NA Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21239 1616 Heathfield Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 8lack, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married Married Yes "natural", or Black Specify 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit Pages 1 and 2 should be filed within 72 hou
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "mati Completed Elementary/Secondary (0-12) College (1-4 or 5+) Market Produce Seafood 2yrs 12th grade 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Thelma Flowers Be Arthell Catlett 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Baltimore, Md 21239 1616 Heathfield Road, Richard Catlett-Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State King Memorial Park Randallstown, Md 2/5/07 4 Donation 5 Other Specify 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service 21215 Baltimore, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or complic ations that caused the **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Ketoacidosis In mediate Cause (Final disease Examiner condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and trar Physician/Medical X UNPENDED AMENDED, PII, 27, per, ME, G865, 3/14/07 TI Box 68760 23d. Date of delivery tending physuse as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 V Unknown Chronic alcoholism Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No certificate page ✓ Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25 Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: 1 X Natural Yes 2 Director: Pendina 24 hours after death. Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

31. Date filed (Month, Day, Year) State FFB 0 5 Registrar

29b. Signature and title of certifie

Tasha Greenberg MD.

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a)



29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 30, 2007

07-00792

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronald D Cochran	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2007 0308
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death Month Day Year January 28, 2007  3. Time of Death Month Day January 28, 2007  1759 hrs
and the same of th	4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center  4b. City, Town, or Location of Death Baltimore  N/A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1
v any	Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location 10d Inside City Limits
Aaryland 28a-f show 1 at nice. ector	Maryland Baltimore Dundalk 1 Yes 2 X No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho perified at since	3013 Liberty Parkway 21222 United States
er death w , or items r must be Funer	11. Marital Status 1
hours after that the state of t	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
5-0036 ed within 72 hour lygiene. other than "natur the Medical Exan Completed	Elementary/Secondary (0-12) 10 Years  College (1-4 or 5+) Laborer  Construction
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medie	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Vearle Cochran  Vivian Jones
21215 should be fill and Mental H is marked afte event, To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
re, MD 2 Land 2 should Health and M fitem 27 is m r traumatic e	Valerie Cockran (Wife)     3013 Liberty Parkway Dundalk, Maryland 21222       20a Method of Disposition     20b Place of Disposition (Name of cemetery, Date     Date       20c Location - City or Town, State
Baltimore, MD Pentit Pages I and 2 sho Department of Fleath and Important: If item 27 is injury or other traumati	1 X Burial 2 Cremation 3 Removal from State crematory or other place) Veterans 4 Dination 5 Other Specify: Crownsville Cemetery 2/2/2007 Crownsville, MD
Baltimo	21 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222
Physician /Medical	23a. Part I. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure that only one cause on each line.  Approximate Interval Between Onset and Death  Immediate Cause (Final disease a. Chronic obstructive pulmonary disease
Examiner	or condition resulting in death)  Due to (or as a consequence of):
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause
tted d ansit Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
0, be execusive sician an outrial - tr	XUNPENDED AMENDED 4.27, perME, g864, 2/20/07 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or ettificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transification: To Be Completed by Physician/Medical Exhibital Certification: To Be Completed by Physician/Medical Exhibital Certification: To Be Completed by Physician/Medical Exhibital Certification: To Be Completed by Physician/Medical Exhibital Certification in the completed by Physician/Medical Exhibital Certification in the completed by Physician/Medical Exhibital Certification in the completed by Physician certification in the certificatio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)  23d. Date of delivery Month Day Year
s, P.O. Bo irres that the dea signed by the a the detached fo	Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
IS, P.C quires that en signed ald be deta	1 Yes 2 No 3 Probably 4 Unknown  1 24a. Was an 124b Were autopsy findings available
tal Records, cian: The law requires certificate has been sig ector, page 2 should be Be Completed	autopsy prior to completion of cause of performed? death?
n of Vital Recling Physician: The I After this certificate I funeral director, page	25. Was case referred to medical 26.Place of Death (Check only one)
of Viting Physicing Physicing After this uneral direction To E	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred
sion c ttending death ctor: Af y the fun	2 Accident Investigation
Division o spital or Attending sours after death neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attend within 24 hours after death To the Finneral Director: completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Office (Check only)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F * F 3   X	29b Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) 29d Date signed (Month, Day, Year) 3 January 29, 2007
	3/. Name and address of person with completed cause of death (Item 23a)
State	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature
Registra	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:42 PM M January 25, 2007 Michael Chrzanowski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore tf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 3; 1962 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F Yrs. Director Poland 219-64-6026 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of 2 should be filed within 72 hours after death with the Marylar th and Mantal Hygiene.

The and Mantal Hygiene.

Ye is marked other then "natural", or Itema 23a or 28a-1 ahow treumatic event, it a Medical Etaminar must be noullisted at MD 1 Yes 2 No Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 828 N. Eutaw Street 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health a important: if item 27 is any injury or other trei once. Joseph Richey Hospice 828 N. Eutaw Street Baltimore, MD 21201 Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☒Other (Specify) in state 21. Signature of Euroral Service Licensee Ronald S. Wade State Anatomy Board 655 W./ Baltimore Street Director Baltimore, MD 21201

23a. Pairt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) **Physician** Sarcomatoid year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): eate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) o. 9 ☐ Unknown م. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 1 Yes 2 No 3 Probably 4 Uriknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 No 1 Yes 2 No : After this certifical funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending nours efter death.
neral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or To the Funeral Direct completely filled in by 4 T Homicide To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier January 26, 2007 20

State Registrar DHMH 17 Rev 1/2001 838

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150 MD 31. Date filed (Month, Day, Year)

FEB 0 5 2007

Hospice

32 Aegistrar's Signature

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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 1.00PM Μ. Douglas Agnes JANUARY 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAL HOSPITAL BALTIMORE BALTIMORE CITY OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 02 Month Day, Year 35 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2**X** F 71 NC Director 237-52-2706 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Catonsville Directo MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 U.S.A. 7 Cedar Bluff Ct. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 基☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Be Completed by X□ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5yrs+ 12th grade VA Hospital Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fi. Health and Mental H tem 27 Is marked ott 2 Pauline Gray Mac Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If item 27 Is any injury or other trau QDCS. Sandra P. Dotson-Daughter 15 Jolie Court, Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) 2/3/07 Woodlawn Baltimore Co, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that obused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): SMALL CELL LUNG CAMPLER Sequentially list conditions, if any, leading to immediate the list in a fine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 20 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) : After this funeral of 28b Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Vithin 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified JANUARY 29, 2007 , M.D RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE m. D SIMAT LOOKMAN LAWAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 2007 Davis January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 96 July 14, 1910 Ohio 301-22-1297 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 ☐ No Directo Ohio Mahoning Youngstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 724 Oakridge Drive 44512 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be finance and Mental F Be Louis Davis Mildred Pavlovich ပ 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 Is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Radovick (Niece) 4001 Greenway; Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Belmont Park Cemetery 2/3/07 Youngstown, OH 22. Name and Address of Facility
Vaschak-Kirila Funeral Home
3100 Canfield Rd., Youngstown, 21. Signature of runeral Service Lic risee unen OH 44511 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosc Immediate Cause (Final **Physician** rears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed the burial-transit Exami and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 4 Unknown 2 ☐ No 3 ☐ Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA ဥ 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury 28h Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and hitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Gunapa 30. Name and address of person tho comple cause of death (Item 23a) (Type, Print) DYMYC Kuvai 31. Date filed (Month, Day, Year) State FEB 05 2007 Registrar

		1	For Amend #	17 Pe	State o	of Marylar 54 2/05	od / Depa	artment of	Health f Death	and Mer	ntal Hyg	iene	דחר	020	00
			Decedent's Name (First								Date of Dea	th		3. Time of	Death
	Physicia /Medic	_	Mau	ırice	Eugen	e Dixo	n, Jr	•		F	Month ebruar	y 1,	Year 2007	5:40	$\mathbf{P}^{M}$
	Examin		4a. Facility Name (If not in	nstitution, gi	ve street and nu	ımber)		4b. City, Town,	or Location				nty of Death	1	
-	- Lorent Manager		Greater B					Tows o		er 24 Hrs.   8.	Data - ( Dist		ltimor		
- 4	Funeral Director		5. Social Security Number 214–26–150		Sex 1□ M 2□ F	7. Age (In yrs.	. <i>iast birthday)</i> Yrs.	Months Day		Min. Ma	Date of Birth (Month, Day y 15,	Year) 1929	9. Birth Cou Mar	place (State o. intry) yland	r r-oreign
(Mary)	Militaria sanaraja hiji interativa		Usual Residence of Dece			1	_				7 1				
	urylan show	_		County	•		ity, Town or Lo							10d. Inside Cit 1 ☐ Yes	
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0	ms 23	Funeral	2924 Wa 2	Lnut	12. Was Dec	cedent Ever in U	J.S. 13.	Was Decedent of Yes, specify Cu		rigin? (Specify	y Yes or No-	14. F	Race - Amer		
<b>ට</b>	ages 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene.  If item 27 Is marked other than "natural", or items 23a or 28a-f show it item 27 Is marked other than "natural", or items 20a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 3 ☐ Widowed 4 ☐ I		Armed F 1  Yes If Yes, G Year or I	2J No		1 Yes, specify Cu 1 □ Yes 2☐N			an, etc.)		Black, White ec <i>ify:</i> Whi	·	
50	2 hou latura	ted	15. I	Decedent's E	  Education  rade completed	1	16a. Dece	dent's Usual Occ kind of work don	upation	et of working		16b. Kind o	f Business/li	ndustry	
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and	d be f ental h ced of c even	o Be	Maurice I			Sr.				th Ga		maraon ban	iamoj		
ary.	shoul ind Me i mark	은	19a. Informant's Name/F				19b. Mailir	ng Address (Stre	et and Num	ber or Rural R	Route Numbe	r, City or To	wn, State, Z	ip Code)	
OZ.	and 2 salth a 27 ls		Maurice E	. Dix	on III					e., Ow	ings	Mill	s, Mo	211	17
×	of He		20a. Method of Disposition		□ Removal from	20b.	Place of Dispo cemetery, cre-	sition (Name of matory or other p	lace)	Date	Э	20c. Locatio	on - City or T	Town, State	
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	Physician		shock, or Heart fail Immediate Cause (Final disease or condition	ure. List onl	y one cause on	each line. RADYC	ARDL	4						Interval Bet Onset and I	ween Death
	/Medical		resulting in death)	4		o (or as a conse	quence of):	241	1 1/4	1.001	11/-				
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	क्रुं र्राष्ट्र	Examiner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	ate $lacktree{ }$	Due (C	o (or as a conse	quence or):								
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	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4⊟Preg 9⊟Unk	gnant at time of nown	death 51	Other (specify)				ŀ		·	
ر. م.	s that i	y P	Part II. Other significan	conditions	contributing to	death but not re	sulting in the u	nderlying cause	given in Par	t I.	23e. Did to	bacco use o	contribute to	the cause of o	leath?
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or	Physic this cral dire	은	1 ☐ Yes 2 ☐ No 27. Manner of Death		12	▼Inpatient 2 [ e of Injury	ER/Outpatie	II OLI DOX		Nursing Home	5 Resid			cify)	
o	ding Fin.	tion		Pending investigati	(Mo	onth, Day Year)	Injury		njury at Vork? □Yes 2[				Joan og		
Division or Vital Records, P.O	or Atter fter deal Director in by the	Certification:		Could not determine	be 28e. Plac buil	ce of injury - At iding, etc. (Spec	home, farm, st cify)	reet, factory, office	се	28f	f. Location (S City or Tow	Street and No n, State)	umber or Ru	ral Route Num	nber,
	ours a ours a neral I		29a. Certifier 1	Certifying I	Physician: To the	he best of my ki	nowledge, dea	th occurred at the	e time, date	and place, and	d due to the	cause(s) and	d manner as	stated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Medical	(Check only 2 2 29b. Signature and title			basis of examinancer stated.	nation and/or i	ivestigation, in m	ny opinion, o					to the cause(s	3)
	With To		Towas 2		ak	MD			773			/	02/07		
	10		30. Name and address of TOMAS2 PAT	of person wh				Print)	BALTI	MORE	MD.	21204	/		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Robert Albright Durham, Sr. 31 2007 3:15 PM Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5801 Emory Road Upperco Under 1 Year | If Under 24 Hrs. Baltimore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 ☑ M 2 ☐ F Director 23,1926 214-26-2570 80 U.S.A. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f shov Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Md. Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5801 Emory Rd. 21155 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Item 27 Is marked other than "natural", or Ite ☐ Yes 2☐ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ρ Specify Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Armco Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Harry Harrison Durham Pearl May Albright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Durham - wife 5801 Emory Rd. Upperco, Md. 21155 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot NO Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pauls Cem. Feb. 3,2007 Upperco, Md. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee that led 3296 Charmil Dr. Manchester, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** -4 month disease or condition resulting in death) malignant /Medical Due to (or as a lonsequence of): Examiner metasta hi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the kerician resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ed by the a detached f ☐Yes 2☐No 9□ Unknown 9 Unknown signed by the Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has your feasion 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

deal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of softifier 29c. License number 29d. Date signed (Month, Day, Year) D0038096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwoods Trail Hampstead all) Linda

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 5

**ORIGINAL** 

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end items 10e, 19b per th 8864 2-5-07 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.--1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 31, **Physician** Helen Marie Fridye 2007 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) 5. Social Security Numbe 156–14–9887 **Funeral** Months Days 1 M 25 F 83 06/11/1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Oak Park Heights Washington 1 XYes 2 □ No Director MN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Park Oakgreen Place North 55082 USA 5486 <del>Oak</del> Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Black, White, 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify ò Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than 12 Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental F Patrick J. McLaughlin Helen Cassidy is marked 19b. Mailing 5486 (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5486 Oakgreen Place North, Oak Park Heights, MV Patricia Marie Moffett/Granddaudhter Health tem 27 i permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place Greenwood Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fox Worth, TX 4 ☐ Donation 5 ☐ Other (Specify) Park Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Demontra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sician and burial-transit resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 hpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / filled in by the f 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of gertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

Stone

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Carmen S. Ferreira State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Time of Deat Month Day January 24, 2007 Medical Examiner 0835 hrs Carmen Silva Ferreira 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 10225 Colesville Road Silver Spring Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** Months Days Hours Min Director 2 X F 212-47-5186 Country) Brasil M 37 July 21, 1969 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No Silver Spring hours after death with the Maryland MD Montgomery Director 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country 20901 Brasil 10225 Colesville Road Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. 14 Race - American Indian Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 X No White Widowed Divorced If Yes. Give Year Yes 2 X No specify. Specify: "natural" ⋛ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene Important: If item 27 is marked other than "I injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Childcare 12 Babysitter 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be João Raimundo Ferreira Elvira Grisante Soares 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 9984 Lake Landing Rd. Montgomery Village, Mariza Alemao/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 02/03/07 Beltsville, MD Chesapeake Crematory Other Specify Donation 5 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service Beverly L. Heckrotte, P.A. Clarksville, MD21029 MO1251 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Seizure Disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Discuss or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed d. and Physician/Medical X UNPENDED <sup>AMENDED</sup> #2,23a,27,perME, attending physician or use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year 2 Fetal death Month Day past 12 months? Pregnant at time of death Other (Specify) signed by the atte Yes 2 No 9 ✔ Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records, After this certificate has been funeral director, page 2 should 24a. Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 2 No Yes To the Hospital or Attending Physician: 25 Was case referred to medical 26.Place of Death (Check only one Be Other<sub>4</sub> examiner? DOA Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 မှ 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No death. within 24 hours after death Fo the Funeral Director: the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E January 25, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FORRES 10 45 AM beerge JANUARY 24 2001 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Months Hours 92 1914 Aug 11, 241-01-7738 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard County General Hospital 5755 Cedar Lane COlumbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director m Approximate Interval Between Onset and Death Preumuns Bacterial Due to (or as a consequence of) Cardiovascular Alterosclerolic Due to (or as a consequence of): hronic Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

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Hydene. other than "natural", or iteme 23a or 28a-f ehov rent, the Modical Examiner roust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturel", or iter any injury or other traumatic event, the Mudical Examiran one.

Baltimore, Maryland 21215-0036

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Waknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3□ DOA 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 | Yes 2 | No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death, occurred at the time, date and others and the to the gaussist and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) & Claum 3064

or Attending Physicien: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760. attending pt cate has been signed by the page 2 should be detached After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

> State Registrar

31. Date filed (Month, Day, Year) FEB 0 5 2007

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARY (TASKINS 48AM JANUARY 2007 \*/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTMORE CENTER RANDALLSTOWN HOSPITAL NORTH WEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number \\\\\ Funeral 75 11-1-1931 Director N.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Y Yes 2 No Director Md. NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 908 E. Eager Street 21202 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black ģ 3 ☐ Widowed 4 K Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Other People Homes 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susie Grissett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Willie Handy Cousin 1218 Winston Avenue, Baltimore, Md. 20a. Method of Disposition 1 ☐ Buria 2 ☐ Crem 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State King Mem. Pk. 2-3-07 Randallstown, Md. 4 □ Donat on 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licenses March F.H. East £1. Signature 1101 E. North Avenue, Baltimore, Md. 21202 23 Part1 Enter the disease, or comolications that caused the death, Approximate Interval Between Onset and Death o not enter the mode of dving, such as cardiac or respiratory arrest or heart failure. List only one cause on each line **Physician** CEREBROVASC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 🗹 No 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ERTENSION 3 Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed MELLITUS BETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated YSICIAN 29d. Date signed (Month, Day, Year) itle of certifier 29b. Signature an 2007

State Registrar

FEB 0 5 2007

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)



NONTHWES

401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30<sup>Day</sup> Month Physician 2007 Grimes 9:09а м Anna /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Manor Care If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5-2-1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF 82 N.Y. Yrs. Director 127-16-8372 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Mydical Examiner in using a nuitled at once. 1 XYes 2 No Baltimore Director NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21218 Apt. 258 4417 Marble Hall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ₺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Soc. Services Rensselaer Co. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brownlow Robinson Hazel William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) \_21218 19a. Informant's Name/Relationship (Type, Print) 4417 Marble Hall Rd. Apt. 258, Baltimore, Md Daughter Pamela Grimes 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-3-07 Baltimore, Md. Garden of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IE FEMALE: nse 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 40
9 Unknown Month Day Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 2 00 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has autopsy 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To funeral dir 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Hatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00061199 Jan, 31, 200 7 18 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles ST, Suite 209, Touson, MD 21204 6.565 Black 32. Figistrar's Signature 31. Date filed (Month State 5 Registrar

		1	For State Registrar	State of M	aryland		artment o				giene Reg. No:	007	03095
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	/Medic	al -	George, Good	ochin						Januar	× 28		
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yla		မှ	Joe	T 0:4	Good		4.11		Kate	/0 / 1/	0: -	Brow	
Maryland	12 th arr		19a. Informant's Name/Relationship ( Emma J. Beard	Niece	1					a <i>l Route Numbe</i> Burnie,	-	0wn, State, 2 21061	up Code)
	if Health itam 27 other tra		20a. Method of Disposition		000	ce of Dispo	sition (Name o	of	G-11 50	Date		tion - City or	Town, State
E O	0 0		1X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		·	Vet.	natory or other Cem.	piace)	2-5-	07	Crown	nsvill	e, Md.
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service Lice		11.0	22	2. Name and A	ddress of F	acility	March	F.H. I	East	
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9 хо	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregn	2004			230	d. Date of del	ivery
Ω.	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a			Other (specif					Month	Day Year
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of V	Physician: this certific ral director,	ToB	examiner? 1 Yes 2 No	Hospital:		R/Outpatier	at 3 DOA	Other: 4[	Nursing H	ome 5 🗆 Resi	dence 6	]Other (Spe	cify)
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4	1		30. Name and address of person who	MD 10	. 1	23a) (Type,	0 1	Balt	timor	e, MI	21-	201	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Aggis	trar's Signati		1-4-			- 1 - 1			
9	Regist	rar	FEB 0 5	2007	was A	K A	Carles !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland (Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 40 A M **Physician** Geathers 2007 )enniter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wildwood Parkway, Apt 2A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 X F 55 South Carolina 248-92-9275 15, Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10h County event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Directo MI 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 21229 1305 Wildwood ARKWA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Tes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Specify Specify: Baltimore, Maryland 21215-0036 Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mental Structor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kachael Holmes ဥ Geathers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Brother MD esville Kd Elijah Holmes 1321 Hobin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 1, 2007 Ballimore, MD Cometery MARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acillax Vaugho C. Greene Funerat Service 7151 Balto. NAt'l Pike Balto. M 21. Signature of Funeral Service Licensee Balto, MD 21229 aug eene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Small Bowel Obstruction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Carcer Overiw Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy perform 1 Yes 2 has 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After i or Attending F after death. Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier

10 State

Registrar DHMH 17 Rev 1/2001 31. Date file (Monh,

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30. Name and ad areas of person who completed cause of death (Item 23a) (Type, Print) WIH I

600

mD 10 32 Registrar's Signature 0060812

30/07

W. Wolfe St Phipps 281 John Hopkers BALTO MD 21292

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

To Be Completed by Funeral Director

	Plea	se Type or									_egible	э.		
For		State of	f Maryla		•			nd M	1ental Hy	giene				
1 - State Registrar				C	ertifica	te of i	Death			Reg. No.	200	7	030	97
1. Decedent's Name	(First, Middle	e, Last)							2. Date of De	eath Day	Ye		Time of D	
Beulah		Marg	guerit	te	Ga	tlin	l		2	2	7	7 1	2:45	-PM
4a. Facility Name (If	not institution	n, give street and nu	mber)		4b. City	, Town, or	Location of	Death		4c.	County of E	Death		
5. Social Security N	lin S umber	guare Vsex	Host 7. Age (In)	rs. last birtho	Months	SEC er 1 Year Days	If Under 24	Hrs.	8. Date of Bir	th av, Year)	alti	Birthplace	(State or F	Foreign
233–14–55!	52	1  M 2 <b>X</b> F		92 Yrs	S				November		14 We		irgin	ia
Usual Residence of 10a. State	Decedent 10b. County		100	City, Town or	r Location							104	Inside City	Limite
Maryland	Balti	more	100.		dalk								1 ☐ Yes 2	
10e. Street and Nur		INOIC		Dan		ip Code				10a Citi:	en of Wha	t Country?	<b>&gt;</b>	-
103 Center		Apt 235			101. 2.		21222				SA	Coodinity:		
11. Marital Status		12. Was Dec	edent Ever ir	n U.S.	13. Was Dec	edent of H	ispanic Origi	n? (Sp	ecify Yes or No	D- 1	14. Race - A		ndian,	
1 □ Never Marri 3 🎞 Widowed		Armed Fi ied 1 ☐ Yes If Yes, G Year or I	2 No ve		lf Yes, sp 1 ☐ Yes	_	Specify:	Puerto	Rican, etc.)		Black, V Specify:	White, etc. Whit	te	
	15. Deceden			1 (G	ecedent's Us Give kind of w	ork done	during most o	of work	ring	16b. Kir	nd of Busine	ess/Indust	try	
Elementary/Second 12 years	ndary (0-12)	College (	1-4or 5+)		fe. DO NOT : 001 Bu		•	t		Bal	timor	e Cou	ıntv	
17. Father's Name (	First, Middle,	Last)							e (First, Middle					
Thomas Rie	ednour						Mae S	tev	ens					
19a. Informant's Na	ame/Relations	hip (Type. Print)		19b. M	ailing Addres	ss (Street	and Number	or Rur	ral Route Numb	per, City o	r Town, Sta	te, Zip Co	de)	
Sidney Gat	tlin		son	844	2 Kava	ingh I	Road,	Bal	timore,	Mar	yland	212	222	
20a. Method of Disp 17 Burial 2 [ 4 Donation	☐ Cremation	3 □Removal from	State	b. Place of Dicemetery,	crematory or	r other plac		ebr	uary 007		cation - City	,		
21. Signature of Fu							ss of Facility uneral	Но	me Of I Road, I	Dunda	lk,P.	Α.		
23a, Part1, Enter th	ne disease, or	complications that	caused the d	eath. Do not							I.K. MO	Ap	proximate	
shock, or hea Immediate Cause ( disease or condition resulting in death)	rt failure. List Final	only one cause on	each line.	Ble sequence of):	ed							Int Or	erval Betwe iset and De	een eath
Sequentially list colif any, leading to imcause. Enter Unde	nditions, nmediate	b	(or as a cons	sequence of):	:							+		
that initiated events resulting in death) I	injury	c	(											
resulting at death) i	_431	d.	(or as a con:	sequence of):										
IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 ₽ 9 □ Unknown	months?		birth 2□F nant at time	etal death	3⊟Ectopic 5⊟ Other (		/			2	23d. Date of Month	-	y Ye	ar
Part II. Other signif	ficant condition	F	leath but not	resulting in th	ne underlying	cause giv	en in Part I.			tobacco u Yes 2[		te to the c	ause of dea	
Ania	mia	) '								opsy ormed?	deat	th?	findings av etion of cau	vailable ise of
25. Was case refer	m 1 a						26 Place	of Deet	1 Yes		1 1	Yes 2□	No No	
examiner?	_	Lannital	Inpatient 2	2 🔲 ER/Outpa	atient 3∏ £	OOA Oth	or:		ome 5□Res		G □Other (	Specify)		
27. Manner of Deat	h 5 🗌 Pendir	28a. Date		28b. Tim	ne of	28c. Injur Wor			28d. Describe			çy)		

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and expensely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical

DHMH 17 Rev 1/2001

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0. Name and ad se s of person who completed cause of death (Item 23a) (Type, Print)

9000 Franklin 32. Registrar's Signature Farnie Drive Baltimore MI 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

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			For State Registrar		Marylan		artment o			R	leg. No.	17	03098
	Physici	an	Decedent's Name (First, Middle							<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	/Medic	al	40 Facility Name (If not institution	GILL			45 Oit T-	1	- ( D + h	2		DOT	6 = M
	Examin	er	4a. Facility Name (If not institution	give street and num	Der)			n, or Location o	or Death		4c. County	or Death Ltimo	
	Funeral		Multi Medical  5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	Towso	ear If Under		8. Date of Birth	1		
	Director		218-07-0313	1□M 2∏F	95	Yrs.	Months Da	ys Hours	Min.	(Month, Day )ec. 29	, 1911	Cour	place (State or Foreign htry) MD
	pud *		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	ecation					1	0d. Inside City Limits
	Aaryla I sho	ō		. •	100.01,							'	1 ☐ Yes 2 ☑ No
	28a-	Director	MD Bal	timore		Reis	10f. Zip Coo			1	l0g. Citizen of V	Vhat Cour	
	3a or	ā	116 Butler Roa	a				21136				USA	
	death rms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13.	Was Decedent	of Hispanic Ori Cuban, Mexican	igin? (Spec	cify Yes or No-	14. Rac	e - Americ	can Indian,
ဖွ	after or Ite		1 Never Married 2 Marri	Armed For ed 1 ☐ Yes If Yes, Give	2 ☑ No		irres, specily 0 1 □ Yes 2 🛣			ucan, etc.)	Specify	k, White,	etc.
5-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f show than Madleal Ezand actinual be codiffied at	d by	3 ₩ Widowed 4 Divorced	Year or Da	ites:							M	Mite
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Maryland	should be ind Mental marked o umatic eve	To B	John W. Wiley					I	da Vi	rginia	Marshal	11	
lan	C1 00 05		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address (Str	eet and Numbe	er or Rural	Route Number	r, City or Town,	State, Zip	Code)
	1 and Health tem 27 other tr		Thomas M. Gill	Son							re, MD		
altimore,	ges f t of H iffle or ot		20a. Method of Disposition 1 XBurial 2 ☐ Cremation			ace of Dispo emetery, crer	sition (Name o natory or other	place)	Da	ate	20c. Location -	City or To	own, State
Ē	t. Pa rtmen rtant:		<ul> <li>4 □ Donation 5 □ Other (S)</li> <li>21. Signation of Funeral Service I</li> </ul>		Dr			netery 2			Pikesv		
Ba	permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other Office.		21. Signature of Fullerasservice i	TO ISOU				Funeral	•				own Road
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	/Medical		disease or condition resulting in death)	a. Due to (c	or as a consequ	uence of):		7				-	275
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	D =	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (	r as a consequ	uence of):	11 13	0					Jeons
	and and	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a consequ	1C	17737						jeons
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joi	endin sath. or: Aft he fur	atio	1 Natural 5 Pendin	ation	, Day 70a7	injury		1 Yes 2	No				
Division of Vital	or Att	ertification;	3 Suicide 6 Could r 4 Homicide determ	ned 288. Place	of Injury - At ho ig, etc. (Specify	ome, farm, str	eet, factory, off	ice	2	8f. Location (S. City or Tow	treet and Numb n, State)	er or Rura	il Route Number,
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	To the within 2 To the complet	Ž	29b. Signature and title of certified	. 00.	5-3-5		29c. Lic	ense number		2	29d. Date signed	(Month,	Day, Year)
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1	0		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	7700	Y	nk s	20 .	>	
	× Sta	to.	31. Date filed (Month. Dav. Year)	32-Re	gistrar's Signa	ture		10005	ON	ME	7 41	204	
	Regist	rar	29b. Signature and title of certified  29b. Signature and title of certified  30. Name and address of person  FERMINAL  31. Date filed (Month, Day, Year)  FFB 0 5	2007	eus l	S SON	gazi s						

		•	For State Registrar	State of Ma	arylan	-	rtmen tificat			and Mo	_	giene Reg. No.	200	7 00	099		
	Physicia	an	1. Decedent's Name (First, Middle, Last)							1	2. Date of De Month		Year	3. Time o			
¥	/Medic	al	Josephine Geer					-	1 2		Januar		2007	9:09	AM M		
	Examin	er	4a. Facility Name (If not institution, give : 3044 Keswick Aven				4b. City,		Location o			County of Deat	h				
	Funeral		5. Social Security Number 6. Sec		e (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Bin (Month, Da		N/A  9. Birthplace (State or Foreign				
Н	Director		218-88-3331	]M 2⊠F	45	Yrs.	Months	Days	Hours	Min.	09/03/	y, Year) 1961	Co	yland			
	p s		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside (	ity Limits		
	Aaryla raho	٥				timore	oation								2 No		
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Maryland 21215-0036	hours tural	d be	3 Widowed 4 Divorced	Year or Dates:		16a. Deced	lent's Heur	al Occupa	ation			16h Kin	d of Business/				
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<u>₹</u>	2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or it aumatic avant, the Mudical Examination avant, the Mudical Examination.	ပို	Eugene Geer								Reinhol						
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ۊ	m O - N		1 ☐ Burial 2 【X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		emetery, crer l l top S				02/06	5/2007		on, Mar				
Baltimore,	permit. Page Department Important: if any injury or once.		21. Signature of Funeral Service License	98					s of Facilit				uck, Ir				
ñ	Per in Per		alexandria JC	Sates		53	305 H	arfor	rd Ro	ad, Î	Baltimo	re, l	MĎ 2121	4	10		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each li	d the death	n. Do not ent	er the mod	e of dying	g, such as	cardiac o	respiratory a	rrest,		Approxima Interval Be	tween		
3	Physician		Immediate Cause (Final disease or condition	mya	can	dias	27	nfo	arct	HOL	$\overline{}$			Onset and	Death		
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ğ	w require been sig should b	edt	Bipolar affe	ective	dis	sord	31				í)SX	Ýes 2⊡	No 3□Pr	obabiy 4 [	]Unknown		
ဝင္ပ	law re es be 2 sho	pie									24a. Was		24b. Were au	topsy findings	available		
Division of Vital Records,	Physician: The lav this certificete hes al director, page 2	Completed by										rmed? 2 ☐ No	death? 1 ☐ Yes		30000		
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Ó	s afte	Certification:	4   Homicide	building, et	іс. (Зресіт	γ)					City or To	wn, State)					
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best	of my kno	wledge, death	n occurred vestigation	at the tim	e, date an	d place, a	nd due to the	cause(s) a	and manner as	stated.	S)		
	thin 2. tha I tha I	Med	one) 29b. Signature and title of certifier	and manner st	ated.	, 11		c. License							-1		
	5 <u>18 5 9</u>		So. Signature and title of certifier	1.0 =		mn				-7-	_		signed (Mont		C. C		
,	5		30. Name and address of person who co	Oscien betelom	leath (Iton	23a) /Tuna	Print)	N	102	- (	1	Nam	yang	47,4	100		
d			Thomas Wilson		) / (IIII)	5(L	عـا ار	ch	Rai	sen	BWd	1,Bo	yang !	emo	2/239		
	Sta		31. Date filed (Month, Day, Year)	32.7 egisti	rar's Signa	iture	)										
	Registr	ar	EEE 0 5 20	07		K B	as &										

ORIGINAL

07-00871 Aniya R Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ **Medical Examiner** 0104 hrs 4015 Grezn February 1, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/Y 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) Funeral Months Davs Director Country) MD 2 × F -75-1630 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show Baltimore MD death with the Maryland rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rdles United States 4125 21213 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married Married Yes 3 Widowed Divorced If Yes. Give Year 1 Yes 2 No specify: Specify: Black "natural" þ 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "i injury or other traumatic event, the Medical E. MD 21215-0036 none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Green Thomason 19a. Informant's Name/Relationship (Type, Print ) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ba Ave. 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State 20a. Method of Disposition Baltimore. crematory or other place) 1 Buria! 2 Cremation Removal from State Park wood  $2\omega 7$ Other Specify Signature of Funeral Service License 22 Name and Address of Faci 11021229 130 x 10 11651 110. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical ned by the attending physician a detached for use as the burial -X UNPENDED A#5336,27,28a-f, perME, g865, 3/14/07 TT • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 ✓ No 9 Unknown death Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 V Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: Other Inpatient 2 ✓ ER/Outpatient 3 Nursing Home 5 Residence 6 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death cation: Natural Yes 2 X No unknown neral Director: filled in by the f Pending Fnd 2/1/2007 Fnd 12:10 am 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 4125 Ardley Avenue 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined (Specify) other-scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the l within 2 To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific O.C.M.E. February 1, 2007 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHIMH 17 KeV 172001 OCME 2006 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Pag N2 11 17

Physician
/Medical
Examiner

**Funera** Directo 1 - State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Modical East injury or other traumatic events.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		1 - State Registrer Certificate of Death Reg. No. 0							03101			
Y		1. Decedent's Name (First, Middle, Las	t)	2. Date of Deat					100 to 100 g	3. Time of Death		
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lic: ine		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Dea	-	4	c. County of De	ath		
		Good Samarita	tal	1	Baltimo	ore, m	aryland	( )	3altim	iorecity		
1		5. Social Security Number 6. Se	7. Age	(In yrs. last t		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	S. 8. Date of Bi	rth	9. 8	irthplace (State or Foreign Country)	
r		213-32-5341	□M 2[ <b>X</b> F	74	Yrs.	MOTHETS Days	riouis Will	04 27		2	SC	
7		Usual Residence of Decedent		40 O' T								
	_	10a. State 10b. County		10c. City, To			10d. Inside City Limits					
	cto	MD NA		Baltimore							¹X Yes 2□No	
		10e. Street and Number		10f. Zip Code					10g. C	citizen of What	Country?	
	ra	1105 Woodbourne					1212		U.S.A.			
	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	as Decedent of H Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	Specify Yes or No rto Rican, etc.)	0.	14. Race - Ar Black, Wi	nerican Indian, nite, etc.	
	Y.	1 Never Married 2 Marned	1 ☐ Yes 2 N If Yes, Give	0	10	☐Yes 🏋 ☐ No	Specify:	Specify: D3			1	
	g D	3 Widowed 4 Divorced	Year or Dates:						1		Black	
	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad	de completed)	16	(Give ki	nt's Usual Occup ind of work done of ONOT use retired	during most of we	orking	160.	Kind of Busines	ss/Industry	
	Ĕ	lementary/Secondary (0-12)	College (1-4or 5- 3yrs	<b>+</b> )	Accounting						otel	
	ပို	17. Father's Name (First, Middle, Last)	SYLD		HCC	Odireziig		ıme (First, Middle			000	
	) Be							nenia K				
	° L	King Dundee  19a. Informant's Name/Relationship (T	vne Print)	10	9h Mailing	Address (Street		Rural Route Numb			Zin Code)	
1		Benjamin Hamlin 20a. Method of Disposition	-Husband			WOODDOL tion (Name of	arne Av	e, Bal		Ore, M. Location - City		
		M☐ Burial 2 ☐ Cremation 3 ☐		ceme	cemetery, crematory or other place)					200, 2004,01, 01, 01, 01, 01, 01, 01, 01, 01, 01,		
		4 Donation 5 Other (Specify) Druid Ridge 2/3/07 Pikesvil.  21. Signature of Funeral Service Lighensee A 22. Name and Address of Facility									le, Md	
		21. Signature of Funeral Service Litters	w /)	psons	Ma	rch F/F	H West					
	_	233 Barti Anter the disease or come	- 1.0.	_				, Balt		re, Mo	21215 Approximate	
ź.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.									Interval Between Onset and Death	
1		Immediate Cause (Final disease or condition resulting in death)		ardial Infarction a consequence of): sclevolic Cardiovascular Diseas a consequence of): tes and hypertension a consequence of):							minutes	
<u>'</u>			Due to (or as a								20	
۱	_	Sequentially list conditions,	b. HThero							e	years	
٦.	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dislos								20	
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	clar	in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at t	2 🗆 Fetal dea	tal death 3 Ectopic pregnancy					23d. Date of delivery  Month Day Year		
	ysi	1 Tyes 2 No 9 Unknown 9 Unknown										
	Completed by Physician	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of										
	o o	1 ☐ Yes 2 No								2XNo 3□	Probably 4 Unknown	
	ete	100 94										
	E E	autopsy									autopsy findings available completion of cause of	
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- 13	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (Check only one)							
	0	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injun (Month, Day						Home 5 Residence 6 Other (Specify)			
	5	1 Natural 5 ☐ Pending	Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		28d. Describe how injury occurred					
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	Certification:	4 Homicide determined	building, etc.	(Specify)	e, farm, street, factory, office 28t. Location (St. City or Town				wn, Sta	or Hural Houte Number, Nn, State)		
		29a. Certifier 1 Certifying Phy	/sician: To the best o	of my knowledge, death occurred at the time, date and place, and due to the								
1	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner stat	examination a	and/or inve	stigation, in my or	pinion, death occ	urred at the time,	date ar	nd place, and d	ue to the cause(s)	
	Z S	29b. Signature and title of certifier				29c. License	e number		29d. D	ate signed (Mo	oth, Day, Year)	
		1	1 . 0			NII	777		1.		76 -7 200-	

Registrar DHMH 17 Rev 1/2001

State

5601

31. Date filed (Month, Day, Year) FEB 0 5 2007

32. Registrar's Signature

		-	For State Registrer	State of Ma	ryland / l		rtment of tificate of			iene () eg. No.	07	03102	
			Decedent's Name (First, Middle, Last)						2. Date of Dear	th Day	Year _	3. Time of Death	
	Physicia		Eveline H.				Hill		o1	26	2007	10:55a M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town	or Location of Dea	ith		nty of Death		
			Manor Care Nur:	s <b>i</b> ng		-	TOT	son		Ba	altim	ore	
	Funeral Director		5. Social Security Number 6. Se 10 247-56-6587		(In yrs. last bii 71	rthday) Yrs.	If Under 1 Year Months Day			Year) 35	9. Birthr Coul	place (State or Foreign htry) SC	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Lo	cation				1	10d. Inside City Limits	
	Mary -f sh	ţ	MD Baltim	ore	Ρi	i kes	sville					1 ☐ Yes 2 No	
	1 the	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen	of What Cou	ntry?	
	3a o		4507 Mary Knoll	Road				21208		Ü.	S.A.		
	deeth ms 2	era	11. Marital Status	12 Was Decedent F	ver in U.S.	13. \	Vas Decedent o	Hispanic Origin?	Specify Yes or No-		Race - Americ		
21215-0036	4 within 72 hours after deeth with the Maryland jiene. 1 than "natural", or Itams 23a or 28a-f show Ita Macileal Examirati: sast ke notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 24 N If Yes, Give Year or Dates:	0		Yes, specify Co	uban, Mexican, Pue o Specify:	no rican, etc.)		Black, White, c <i>ify:</i> B	lack	
Ö	2 hou		15. Decedent's Edu	ucation	16a	a. Deced	lent's Usual Occ	upation ne during most of w	orking	16b. Kind o	f Business/In	dustry	
215	hin 7.	pie	(Specify only highest grad	College (1-4or 5-	+)	life. I	DO NOT use reti	red)	Urking				
21	T1 100 to 100	Completed	10th grade	na		(	Chef				ivate		
	be filed within tal Hygiene. Id other than svent, Inc. Me	Be (	17. Father's Name (First, Middle, Last)						ame (First, Middle,		name)		
Maryland	0 5 0 0	10	Richard Hancock	Sr.				Mary	Campbell	•			
ary	s ma		19a. Informant's Name/Relationship (T	ype, Print)			3		Rural Route Numbe				
	0 2 5 0		Richard Hancock	-Brother								Md 21208	
re	of He Item		20a. Method of Disposition		20b. Place o		sition (Name of natory or other p				on - City or To		
Ĕ	Page nent c nt: If		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Glen	vie	w Mem.	Park 1	/31/07	urha	m, NC		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licens	March		Ma	Name and Add	H West	, Baltin	nore.	БМ	21215	
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do							Approximate	
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	θ.							Interval Between Onset and Death	
	Pnysician /Medical Examiner		disease or condition resulting in death)	a	Card		Inta	ret			- 1	minutes	
9				Due to (or as a	a consequence	e or):							
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
	eath certificate be executed attending physicien and for use as the burial-transit	xar											
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687	icate phys	dical		0.									
	certif iding ise a	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant							23d.	Date of deliv	of delivery	
Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be deteched for use as the burial-transit	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			]Ectopic pregna ] Other (s <i>pecify</i> )				Month	Day Year	
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	that the de led by the a deteched	Y P	Part II. Other significant conditions co	ontributing to death bu	ut not resulting	in the u	nderlying cause	given in Part I.	23e. Did to	bacco use o	contribute to t	the cause of death?	
Records,	w requires that been signed b should be dete	d by							1 🗆 Y	es 2 N	o 3 Pro	bably 4 ∐Unknown	
Ö	v req beer shou	Completed							24a. Wasa	an 24	4b. Were auto	opsy findings available	
Zec	ysician: The lav is certificete has director, page 2	E D							autop perfor	med?	death?	opsy findings available ompletion of cause of	
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of	Phys this al dii	. To	1 Yes 2 No	1 🗆 Inpatie		outpatier . Time o	IT 3 DUA	4 Nursing	Home 5 ☐ Resid			(Ty)	
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Sic	Attending Physician: r death. sctor: After this certific by the funeral director,	cal	3 Suicide 6 Could not be		ırv - At home	farm st			28f. Location (S	Street and No	Number or Rural Route Number,		
Division of	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					City or Tow	City or Town, State)			
	pitel purs erel filled		29a. Certifier 12 Certifying Ph	vsician: To the best	of my knowled	ge, deat	h occurred at the	time, date and pla	ice, and due to the	cause(s) and	manner as	stated.	
	Hos 24 hc Fun Fun	Medicai	(Check only 2 Medical Examone)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and								to the cause(s)	
	ithin the comple	ĕ.	29b. Signature and title of certifier	- //			29c. Lic	ense number		29d. Date si	gned (Month,	, Day, Year)	
1	F 3 F 8			es mo			Do	06/199	7	Jan	,26,	2007	
1	1		30. Name and address of person who		eath (Item 222	) (Type						,	
3			Jason Black.	SJ65 /V	OVA C	har	65 ST	, Suite ;	109 , Toi	Sou	MD	21204	
	St: Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 5 2007	32. Registra	ar's Signature	ach	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2;45 A M 04, Herman George Hodges Jr. 2007 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview M.C. Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Min. M 2□ F Months Hours Maryland 82 217-12-5295 3-28-1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1x Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Items 23a U.S.A. 322 S. East Avenue 21224 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status and Mental Hygiene.
Is marked other than "natural", or Item
aumatic event, the Medical Examiner I Armed Forces?

1 X Yes 2 No A.F. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Army/ Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Warehouseman Carlings Brewery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Herman G. Hodges Sr. Margaret Bloom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. Fannie M. Hodges- Spouse 322 S. East Avenue Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer Cem 2-6-2007 Baltimore, MD 4□Donation 5♥Other (Specify)Entomb Eneral Service Licensee 22. Name and Address of Facility
Joseph N. Zannino Jr. F.H. Conkling St. Baltimore, MD 21224 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or comocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of yone cause on each line. Immediate Cause (Final Physician ASCVO Long-Standing disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? ✓es 214 No 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes s after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Pante 2/5/07

DHMH 17 Rev 1/2001

31. Date filed (Month State 2007 Registrar

Hardin

4940 Eastra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pantle

7-0061115

Avenue, Baltomore,

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Edward Marvin Hibbard Kenneth January 29,2007 11:12 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1749 Drexel Road Dundalk Baltimore Co. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🛣 M 2 🗆 F **Director** Jan. 26, 1951 Maryland 56 219-52-4416 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 TXNo Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 1749 Drexel Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 2√No 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3 ☐ Widowed 4 ☑ Divorced Year or Dates: White 'natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Years Auto Mechanic Auto Maintenance alth and Mental Hygid 27 is marked other r traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth E. Sachs Kenneth R. Hibbard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 is any injury or other trau Tiffany L. Hibbard (Daughter) 319 Maitland Street Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2/2/2007 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland art1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ediate Cause (Final ase or condition in the cause of the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 TEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2□ No P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Self inflicted gun shot wound to head Certification: Injury 1 Natural 5 ☐ Pending January 29 2007 | 1/2 A M 1 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗌 Yes 2 No investigation 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be determined Location (Street and Number of Bural Route Number, City or Town, State) 749 Dresel Rd. Dundalk, MD 21222 Dundalk, MD

law requires that the death certificate be executed Division or Vital Records, Il Director: / within 24 hours a

To the Funeral C

completely filled

within 72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

State

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dav. Year) January 31, 2007

30. Name and address of person who completed cause of death (Item 3a) (Type, Print) 6 Trimble H:11CT Lutherville Md 21093

31. Date filed Month, Day, Year)

29a. Certifier

(Check only

Medical

0 5 2007

Registrar

			1_ For State	State of Marylan				Mental Hyg	iene	00105	
			Registrar	<del>.</del>	Cei	rtificate of l	Death		g. No U U /	03103	
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Deatl Month	Day Year	3. Time of Death	
	/Medi	cal	Sr. M. Gertru  4a. Facility Name (If not institution, given		. S . M .	th City Taylor	ttit Bth		1, 2007	11:0BM	
4	Examir	ner	The Villa	e street and number)		Baltim	Location of Death		4c. County of Dea		
	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		timore	
	Director		220-54-8376	1□M 2□XF 84	Yrs.	Months Days	Hours Min.	(Month, Day, 7 - 31 - 1	9 2 2	thplace (State or Foreign ountry)  MD	
	p .		Usual Residence of Decedent  10a. State 10b. County	100 6	y, Town or Lo						
	ehov	5								10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	28a-f	ect	MD Balti  10e. Street and Number	more Bal	timor	e 10f. Zip Code			g. Citizen of What C		
	with Sa or	by Funeral Director	6806 Bellona	Δ. γ. ο. η. η. ο.		2121	2		USA	Suritiy ?	
	death me 2;	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.1	Was Decedent of Hi f Yes, specify Cuba			14. Race - Ame	erican Indian,	
9	or ite	Ē	1 🛣 Never Married 2 🗌 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1			Rican, etc.)	Black, Whi		
93	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or fleme 23s or 28s-1 ehow ther the Medical Examinar must be notified at	db	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√€ No	Specify:		Specify: Wh	ite	
5	natu natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa	during most of worl	king	16b. Kind of Business	/Industry	
121	within ane. then	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retired	"		T 1		
<b>d</b> 2	filed Hygi ther out,		17. Father's Name (First, Middle, Last		1	eacher	18. Mother's Nam	ne (First, Middle, M	Educati Maiden Surmame)	on	
an	id be ental ked c	To Be	Robert Chambe	rs Hardin			Anne M	arie Gu	nzelman		
Maryland 21215-0036	shou and M mar umat	-	19a. Informant's Name/Relationship	Type, PBo#ligious	19b. Mailir	ng Address (Street a	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)	
	and 2		Sisters of Mer	cy-Order	1300	E. Nor	thern P	arkway,	Balto.,	MD 21239	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "natural", or iteme 23s or 28s-f ehow any injury or other traumatic event, the Medical Examinal must be notified at ance.		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Dispo semetery, crer	sition (Name of natory or other plac	e)	Date 2	20c. Location - City or	Town, State	
Ë	Pag ment ant:		4 □Donation 5 □ Other (Speci	(y) W		wn Ceme			Woodlaw		
Sall	Depart Depart Import any in	1	21. Signature of Funeral Service Lice	nsee						neral Home	
	402 # Q		THUM.						Rd., 21		
Н			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			- 4	•		Approximate Interval Between Onset and Death	
M	Physician /Medical		disease or condition resulting in death)	a. Upper  Due to (or as a conseq  DVAVia	g astro	. Mestind	blee	de		Iday	
- 1	Examiner			. 42	2 YV.						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~ ~ ~	1100-510-	31	100				
	outed ansit	Examiner	resulting in death) Last  Due to (or as a consequence of):								
oʻ	e exe										
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien end page 2 should be detached for use es the burial-transit	lical		d							
x 68	ertific ling p	Med	IF FEMALE:	22- 11							
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year	
P.O.	y the	ıysıc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	leatii 5	Other (specify)					
	s that ned b a deta	by Physician/Med	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
Records,	quire on sig uld bu	ed b						1 □ Ye	s 2 🗹 No 3 🗆 P.	robably 4 Unknown	
သ္တ	awre	Completed						24a. Was ar	24b. Were a	utopsy findings available	
æ	The I	E						autopsy perform	red? death?	completion of cause of 2 □ No	
ital	ian: artifice ctor.	BeC	25. Was case referred to medical examiner?				26. Place of Dear	th (Check only one		2010	
of Vital	Physician: this certificatal director, p	၉	1 ☐ Yes 2 ☐ No		EP/Outpatier	it 3□ DOA Othe	er: 4 Nursing H	ome 5 Reside	nce 6 Other (Spe	cify)	
Ē	e fite	i.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at 28d. Injury Work?					d. Describe how injury occurred		
Sio		cat	2 Accident investigation 3 Suicide 6 Could not be								
Division	or A	Certification:	4 Homicide determined		ome, larm, str y)	eet, lactory, office		281. Location (Str. City or Town	eet and Number or R , State)	ural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	a C	29a. Certifier 1 ☐ Certifying P	hysicien: To the best of my kno	wledge, death	occurred at the firm	ne, date and place	and due to the co	usa(s) and manner a	s stated	
	ne Ho	Medical	(Check only 2 Medical Exe	miner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my or	pinion, death occur	red at the time, da	ite and place, and du	o to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	1 -		29c. License		29	d. Date signed (Moni	h, Day, Year)	
	<		mien -pon	Kp us		(	31865		2/1/	07	
1	7 1		30. Name and address of person who	completed cause of death (Item	п 23а) (Туре,	Print)		/			
	)		Mia-Dow Ko	ung Rm		821	₩.	Entan	street	Baltimore 21201	
	Sta		31. Date filed (Month, Day, Year)	32. Filigistrar's Signa	atury A	rest			marylma	21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 12:40 PM HATFIELD 38 NANCY JANUARY 2507 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CENTER ANNATOLIS ANNE ARUNDEL ARUNDER MEDICAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖫 F Director 76 Mar 8. 1930 409-40-9725 Alabama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Crownsville 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1446 Wilderness Ridge Road 21032 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Status Armed Forces 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) real estate broker property permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, Important: If Item 27 Is marked othe any injury or other traumatic auch 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Samuel Carpenter Charley Marlene Welsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Hatfield 1446 Wilderness Ridge Road Crownsville, MD 21032 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Ware, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 23a. Pakt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death Physician disease or condition resulting in death) SE7 SIS DAYS /Medical Due to (or as a consequence of): Examiner PERITONITIS 3 DAYS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed PRIMARY BILIARY CIRRHOSIS YEARS burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d 1 Tyes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performe certificate director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural (Month, Day or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 24 hours a Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only

State Registrar

DHMH 17 Rev 1/2001

within 2.

FFB 0 5 2007

WOLF, MA

one)

BRIAN E

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

116

32

MP

29c. License number

DCC 61776

SUITE 400,

29d. Date signed (Month, Day, Year)

MD

JANUARY

ANNAPOLIS

28, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1243 PM Florence Hong January BOUT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HENES SAINT BALTIMORE If Under 1 Year If Under 24 Hrs. HOSPITAL 8. Date of Birth (Month, Day, Ye Oct 16, 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** Days Hours Months 1 □ M 2 ☑ F 80 1926 218-22-2225 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at MD 1 ☐ Yes 2☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 815 Winters Lane #305 21228 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ð Specify: white 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) the factory worker venetian blinds/umbrella 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph Angell Anna Crouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Hong/son 7202 Johnnycake Road Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₩9ther (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Sign the e of Funeral Scryic vice Licensee d S. Wade Director Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate duse (Final disease or condition resulting in death) **Physician** LEURAL EFFUSION /Medical Due to (or as a consequence of): **Examiner** ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Records, P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 📆 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has director, page 2 : autopsy performed? Yes 22 No death? Vital / Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: hpatient 20 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA After this Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 5 2007

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 4:34 AM Ohnson January 2007 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Samaritan Hospital Baltimoize Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 65 220-36-6512 9-18-1941 Md. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 No Md. NA Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 and 10 may injury or other traumatic event, the Medical Examiner must he mone. 21213 USA 2735 Chesterfield Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: Black ò 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goodwill Industries Sorter 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Foster Johnson Dora Ernest 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21213 2735 Chesterfield Avenue, Baltimore, Md. Sister Dorothy Dixon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Name | 2 Cremation | 3 Removal from State | 4 Donation | 5 Other (Specify) 1-31-07 Dundalk, Md. Trinity Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., Baltimore, Md. andr ) anno 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to ( as a consequence of): Examiner lailure Renai Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a nonsequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Ainpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day,

Dmitriy

32. Regiştrar's Signature

Ineli's



M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Power Blud

D63382

Baltimore, MD

01/26/2007

			1 - For State Registrar	State of	Marylar	•	artment rtificate			and M		giene Reg. No. 0	)7	03109
	Physici	an	1. Decedent's Name (First, Middle, Las	t)			-5 1				2. Date of De	ath Day	Year	3. Time of Death
	/Medic		dames					nns			Januar	1 000	2007	16:50 M
	Examir	er	4a. Facility Name (If not institution, give J.H.H.	street and numb	oer)				Location o			4c. County		
			Social Security Number 6. S	1 7	Age (In vrs	last birthday)	If Under 1		If Under 2		8. Date of Birt	th I	9 Birthr	nlace (State or Foreign
п	Funeral Director			M 2□F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year) -1927	Cour	olace (State or Foreign ntry)  Md.
	g		Usual Residence of Decedent											
	anylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo		10.0					1	10d. Inside City Limits  1 Yes 2 □ No
	A Marie Mari	Director	Md. N	Α		Do	ltimo					40.000.41		
	72 hours after death with the Maryland neture!', or items 23s or 28s-f show littel Examinar must be indiffied at	급	10e. Street and Number 1901 Oakhill Ave	7110			10f. Zip (	1218				10g. Citizen of \	ntry ?	
	eath	Funeral	11. Marital Status		ent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No									can Indian.
(0	r iten	표	1 ☐ Never Married 2 ☐ Married	Armed Ford	es? ⊡ No			* 7		i, Puèrto I	Rican, etc.)		ck, White,	
93	ei'.o	Ď	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1 ☐ Yes 2	No.	Specify:			Specify	a BI	.ack
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "neturel", or items 23s or 28s-f show other than "neturel", or items 23s or 28s-f show event, the Medical Examinar manife notified at	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual kind of work	k done di	urina most	t of workir	ng	16b. Kind of B	nl/esenieu	dustry
121	within ene. then	Ig Ig	Elementary/Secondary (0-12)	College (1-4	or 5+)		<i>no not</i> use Nuctio		_			Nation	al Ca	an Co.
2	filed v Hygie other t		8th grade  17. Father's Name (First, Middle, Last)			PLOC	uccio			r's Name	(First, Middle.	Maiden Suman		
<u>la</u> u	ould be Mental Marked o	17. Father's Name (First, Middle, Last)  James  19a. Informant's Name/Relationship (Type, Print)				Wilson Pensacola						ohnsc	on	
Maryland	2 6 9 7		19a. Informant's Name/Relationship (1) Phyllis Johnson (1)	Daug	19b. Mailir hter 5	ng Address 5520 D	(Street a	nd Numbe	or or Rura Venue	<i>IR</i> oute Numbe e, Balt	ar, City or Town, imore, l	State, Zip Md •	21206	
re,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	1	— Place of Dispo cemetery, crer	sition (Nam	e of her place	, [	D	ate	20c. Location -	City or To	own, State	
E	Pages nent of i ont: if its		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		rrison				1-3	1-07	Owing	s Mil	lls, Md.	
Baltimore,	permit. Pag Department Importent: t any injury o	4 Donation 5 Other (Specify)					Name and			y I Ave.	March F , Balti	.H. Eas more, M	t d. 2	21202
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cau	used the dea	th. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Ch	ani'r	Obch	-/ \   C	his	e F	PUL	na na	y Disc	osc	Onset and Death
4	/Medical Examiner		resulting in death)	Due to (o	as a consec	quence of):				, , , , ,		/		
	Lxammer	۰	Sequentially list conditions	b. Due to fe	r as a consec	oueres of								
	led sit	nlne	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (0:	as a consec	quence or).								
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (o	r as a consec	quence of):							_	
8760,	cate be executed only sician and the burial-transit	calE		d.										
9	tificate ig phys as the	led (												
Вох	eath certific ettending pi for use as 1	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn		Ectopic pre	nnancv					te of delive	
O. B	et the dear by the ett rached fo	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nt at time of		Other (spe					Мо	ntn	Day Year
٥.	thet the		Part II. Other significant conditions of	ontributing to dea	th but not re	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco use cont	ribute to t	he cause of death?
Vital Records,	Physician: The law requires thet the death certificate be executed this certificete has been signed by the ettending physician and rall director, page 2 should be detached for use as the burial-transit	d by									1 🗆 1	res 2 No	3 Prot	pably 4 Unknown
00	aw require s been si 2 should t	Completed									24a. Was	an 24b.	Were auto	ppsy findings available
æ	The lay	E										rmed?	death?	mpletion of cause of
ita	octificete rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only o			
of V	hyeic his ce I dire	5	1 Yes 2 No	Hospital: 1 K In	patient 2	ER/Outpatier	it 3□ DO/	A Othe	r: 4 □ Nu	rsing Hor	ne 5 Resid	dence 6 Oth	er (Specif	<b>5</b> y)
ū	on life		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of (Month)	Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe t	now injury occur	ed	
Sio	Attending r death. sector: After by the funer	cat	2 ☐ Accident investigation				М		′es 2 🗆 1		204 1	24 41		
Division	after din by	27. Manner of Death  1 Natural  2   Accident investigation  3   Suicide   4   Homicide   Month, C				ify)	eet, factory,	опісе		4	City or Tox		er or Hura	al Route Number,
	To the Hoepital Within 24 hours of To the Funaral I completely filled	2 Accident 3 Suicide 4 Homicide 28e. Place of In building, e 4 Depth 1 Depth 1 Depth 2					best of my knowledge, death occurred at the time, date and place, and due to the sis of examination and/or investigation, in my opinion, death occurred at the time, or stated.					to the cause(s) and manner as stated.  time, date and place, and due to the cause(s)		
	one) and manner sta 29b. Signature and title of certifier						29c.	License	number			29d. Date signe		•
	, 1		Collegen Have	ndon M	rdi'col	Doct	5/ 1	Les	- 6	200		Junus,	· v 2	3,2007
(	511		30. Name and address of person who	displeted cause							Balhmore			
	V		Collern Harring	an, Th	John		Kus 1	torr	utol	60	ONON	h Wolf	Str	ret-Maryland
	Sta Regist		31. Date filed (Month, Day, Year) U	gistrar's Sign	H A	nach p	)						01287	

DHMH 17 Rev 1/2001

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Aillia Jaleiilozuk	1- For State	Certificate of Death	Reg. No. 200	7 03116
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examiner	ANNA JAREMCZUK  4a. Facility Name (if not institution, give street and number)	Lab Cu. Taura and analysis of 5	January 29, 2007	1811 hrs
,	742 South Curley Street	4b. City, Town, or Location of Daltimore	Death 4c. County of Death N/A	1
Funeral	5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday) If Under 1 Year If Under 2	4Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Bir	
Director	216-52-1258 1 M 2XF	84 Yrs. Months Days Hours	Min. 12/22/1922 Foreign Co	untry) UKRAINE
any	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Location		10d. Inside City Limits
* .	MD N/A	BALTIMORE		1 X Yes 2 No
the Maryland as or 28a-f show riffed at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cour	ntry?
Di life e	742 S. CURLEY STREET	21224	U.S.A.	
er death with t , or items 23a r must be not Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	ver in U.S. 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pe		can Indian, Black,
ter dee ", or i	1 Yes 2 Yes 3 Widowed 4 Divorced If Yes, Give Year	【 No 1 Yes 2 X No specify:	Specify WH]	. ጥፑ
atural" tamine	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decedent's Usual Occupation (Give kin	d of work done 16b. Kind of Business/I	
5-0036 ed within 72 hour bygiene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+	′	1	
5-0036 lled within 7 Hygiene I other than the Medica	7 17. Father's Name (First, Middle, Last)	HOUSEWIFE  18 Mother's N	Aame (First, Middle, Maiden Surname)	STIC
215 be filed mtal Hy rked of ent, the	UNKNOWN GERRA		NKNOWN	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene Important: If item 27 is marked other ti injury or other traumatic event, the Med	19a. İnformant's Name/Relationship (Type, Print )		r or Rural Route Number, City or Town, State	
, MD and 2 sho ealth and em 27 is em 27 is	JOHN JAREMCZUK/ SON  20a Method of Disposition	347 S. LEHIGH ST	REET, BALTIMORE, MD	
Baltimore, pernit. Pages l at Department of Hes Important: If ite	1 Burial 2 X Cremation 3 Removal from State	crematory or other place)		
uit. Pa artmen ortant ry or o	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			E, MARYLAND
Balt permit. Departr Import injury	Andrew L. Dowell per dvr	1901 EASTERN	R INC. FUNERAL HO AVENUE, BALTO., MD.	21231
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	ne death. Do not enter the mode of dying, such as card	lac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Head Injuries  Due to (or as a consection)	wience of		Death
	Sequentially list conditions, b.	period off.		
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ted Insit Examine	events resulting in death) Last Due to (or as a consecutive for the property of the consecutive for the property of the consecutive for the property of the property of the consecutive for the property of the consecutive for the property of the property o	uence of):		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit eddical Certification: To Be Completed by Physician/Medical Exiteditication: To Be Completed by Physician/Medical Exiteditication:	d.  UNPENDED X AMENDED 21	per fh g864 2-5-07 vt	<del>-</del> -	-
760, cate be execut physician and the burial - tra	IF FEMALE: 23c. If yes, outcome		23d. Date of delivery	,
687 ertific iding p	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pr	egnancy Month [	Day Year
). Box 687 the death certific by the attending p tiched for use as th Physician/	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)		
, P.O. Box 68: res that the death certifi signed by the attending be detached for use as I d by Physician	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Part I		
Records, P.( The law requires tha ficate has been signed to page 2 should be det Completed by			1Yes 2 ✔ No 3Prob	
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Rec : The fificate r, page	25. Was case referred to medical	00 00 00 00 00 00 00 00 00 00 00 00 00	1 Yes 2 No 1 Yes	es 2 No
of Vital Records ing Physician: The law requiring Physician: The law requiring Physician in the law been where all director, page 2 should in: To Be Complete	examiner?  1 V Yes 2 No  Hospital: 1 Inpatien	26.Place of Death (Ct t 2 ER/Outpatient 3 DOA Other	ursing Home 5 Residence 6 V Other	Scene
n of Vi	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject fell down stairs	
ivision or Attendi after death. Director: A in by the fi	2 Accident Investigation Jan 29, 2007	1730 hrs	Subject lell down stalls	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach ledical Certification: To Be Completed by P	Suicide Could not be determined (Specific) Tour	rry - At home, farm, street, factory, office building, etc.  nhouse / Rowhouse	28f. Location (Street and Number or Ru or Town, State) 742 South Curley Street, Baltimore	
D To the Hospital within 24 hours To the Funeral completely filled	20a Cartifier	knowledge, death occurred at the time, date and place		
To the He within 24 To the Fu completel	(Cristin Sin)	ination and/or investigation, in my opinion, death occur	* *	
Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	
	Joishe Josef M	O.C.M.E.	January 30, 2007	
5	<ol> <li>Name and address of person who complete cause of de Tasha Greenberg MD. Assistant Medical</li> </ol>	·	, MD 21201	
State	31. Date filed (Month, Day, Year) 32. Resistrar's EB 0 5 2007	s Signature		
Registrar	FEB 0 5 2007 See	ORIGINAL		
DHMH 17 Rev 1/2001				

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **20**67 3:20 PM **Physician** MAGGIE EUNICE JONES /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Bladensburg, MD 4116 - 56th Avenue 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🖾 F 64 246-66-5128 Yrs Director 09-11-1942 Roxboro, N.C. Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Marylend Depertment of Health end Mantel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f ehow any injury or other traumatic event, the Madical Exempted. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 □ No **Bladensburg** P.G. Completed by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20710 4116 - 56th Avenue Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Yes 20 No 1 Never Married 2 1 Married 1 ☐ Yes 2 € No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>Federal Government</u> Program Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Magnolia Foy Jessie James Hicks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 4116 - 56th Avenue, Bladensburg, MD 20710 Foy Jones/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mill Hill Bapt. Ch. Cemetery 1/20/07 Roxboro, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityFrazier's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 389 Rhode Island Avenue, N. W., Wash., DC 20001 #454 Harrison 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metastatic Breast Cancer Examiner Due to (or as a consequence of) Examine or Attending Physician: The law requiras that tha death certificate be executed after death. physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Bipolar Disease by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 24 140 1 ☐ Yes 2 ☐ No After this cartificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 51 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To in by tha funerel 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 27. Menner of Death 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State Registrar

DHMH 16 Rev 6/95

To the I within 2 To the I

Ine

29b. Signature and title of certifier

30. Name and address of person who

31. Date filed (Month, Day, Year)

completed cause of death (Item 23st) (Type, Print)

Registrer's Signature

HIGGS-SHIPMAN

32.

29c. License number

29d. Date signed (Month, Day, Year)

9200 Basil Ct. Largo, MD 20774

07-00895 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jacob H. James 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 1, 2007 1138 hrs Medical Examiner Jacob Henry James 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Franklin Square Hospital Rosedale 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (in yrs. last birthday) **Funeral** Foreign Hours 219-86-4693 Director 01-20-1974 Country) MD 33 1X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State Essex 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. MD Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland irector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 913 Holgate Dr., Apt G ﻕ Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Married Yes 1 Yes 2X No specify: White f Yes, Give Year Specify: Divorced 3 Widowed 'natural", ⋧ r Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Durrett Sheppard of Health and Mental Hygiene. If item 27 is marked other than event, the Medical Baltimore, MD 21215-0036 Warehouse Worker 8 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henrietta B. James Raymond David Mumma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) or other traumatic 8 North Kresson St., Baltimore, MD 21224 Henrietta B. James / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/6/07 Baltimore, MD Gardens of Faith Department o Donation 5 Other Specify 22. Name and Address of Facility Rendon-Bailey Funeral 21. Signature of Funeral Service Licensee Home, P.A. M01452 21224 2818 E. Baltimore St., Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Bilateral pulmonary thromboemboli Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Deep venous thrombosis of leg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause ne. Due to (or as a consequence of) Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and trans. s attending physician a for use as the burial - t AMENDED UNPENDED

Physician/Medical IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year 2 past 12 months? Pregnant at time of death Other (Specify 5 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 V Inpatient 2 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other 1 V Yes 28c. Injury at Work? 28d Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No 5 Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Death

29d. Date signed (Month, Day, Year)

February 2, 2007

Registrar DHMH 17 Rev 1/2001 OCME 2006

Division of Vital Records, P.O. Box 68760,

has been signed by the 2 should be detached

this certificate

After

To the Funeral Director:

Medical

State

one)

29b. Signature and title of certifier

Tasha Greenberg MD.

31 Date filed (Month, Day, Year)

death.

within 24 hours after

ORIGINAL

and manner stated.

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician ,200 F lankalsk anuary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba Umbra Balhmore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 -/7 -/9 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 F 220-20-8930 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No ms Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 607 21224 USA Completed by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 1 NO 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -Son Kobert. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methodrof Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State -5-07 ak Lawn Baltimore, mo 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bradley - ASL ton Funeral Home 21. Signature of Funeral Service Licenses Willow Spring Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a our sequence off Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ 2 Fetal death in the past 12 months? Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H0 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Medical Certification: To Be Other: 1 Yes 2 No 5 Presidence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖵 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVERDO tern Av, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 05

2007

			For Stete Registrer	State of Maryla		epartment of F Certificate of			giene Reg. No.	2007	03115
Ī	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle,  4a. Facility Name (If not institution,	Jennir	as	4b. City, Town, o	r Location	2. Date of De Month	Day	Year 35 30 County of Deat	
	Funeral Director		5. Social Security Number 217-66-7946 Usual Residence of Decedent	1 M 2 M F 49		If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bin Min. (Month, Da Aug 9,	v. Year)	o Birt Mary	hplace (State or Foreign Juntry) y 1 and
	Maryland -f ehow	tor	10a. State 10b. County MD	10c. (	•	or Location Baltimore					10d. Inside City Limits 1 Yes 2 □ No
	with the	Direc	10e. Street and Number 2661 W. Lafayet	-a Street		10f. Zip Code	2121	6	10g. Citiz	en of What Co	,
036	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or Iteme 23a or 28e-f ehow event, the Madical Examinational te notified at	by Funeral Director	11. Marital Status  1 💆 Never Married 2   Marrie 3   Widowed 4   Divorced	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Or	igin? (Specify Yes or No n, Puerto Rican, etc.)		USA  4. Race - Ame Black, White  Specify: W	rican Indian,
21215-0036	d within 72 ho giene. or than "natur. the Madical.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12) 12		16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired nursing a:	during mos	st of working		d of Business/	,
	a a a a s	Be	17. Father's Name (First, Middle, La Perring C. Jenn					er's Name <i>(First, Middl</i> e, ie Ruth Lit			
Maryland	ges 1 end 2 should t of Heelth and Men if item 27 le marke or other traumatic	ဥ	19a. Informant's Name/Relationshi		19b.	Mailing Address (Street		er or Rural Route Numbe			Zip Code)
	1 end Heelth Iem 27 other tr		John W. Jenning 20a. Method of Disposition		Place of	Disposition (Name of		Avenue Balt		e, MD ation · City or	212 <u>16</u> Town, State
altimore,	permit. Pages Depertment of Importent: If it eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Spe	city) in state	cemetery	v, crematory`or other plac	1				
Ba	Dependimber important		21. Signature of Eyneral Project Li	Wade Directo	or	State Ana Baltimore	tomy MD	Board 655 W 21201	. Ba	ltimore	Street
	Physician /Medical Examiner put	Examiner	23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Sause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Superior (or as a const	equence o	n: Qubitu	g, such as	cardiac or respiratory at	rest,		Approximate Interval Between Onset and Death 7 days
68760,	ificate be executed g physicien and as the burial-transit			Due to (or as a conse	bu.	ed					7 days
.О. Вох	The law requires that the death certificate be executed tie has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23	3d. Date of deli Month	ivery Day Year
<u>က်</u>	res that igned b be deta	þ	Part II. Other significant condition	s contributing to death but not re	esulting in	the underlying cause giv	en in Part I				the cause of death?
Records,	w require been signature should to	ieted	Seizus Os	MANY				24a. Was	res 2 □		obably 4 priknown
		Completed	Sarcoidos	1,6				autop perfo 1 \( \text{Yes}	rmed?	prior to death?	completion of cause of 2□ No
of Vital	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Out	patient 3 DOA Cth	or	of Death (Check only oursing Home 5 Resid		[]Other (Co.	
on of	Attending Physician: If death. ector: After this certific by the funeral director,	lon: To	27. Manne of Death	28a. Date of Injury (Month, Day Year)	_	ime of 28c. Injur	y at k?	28d. Describe I			any)
Division	를 들는 드	Certification;	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be	home, far		Yes 2			Number or Ru	ıral Route Number,
	e Hospitai 124 hours e e Funeral letely filled	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my k taminer: On the basis of exami and manner stated.	nowledge, nation and	death occurred at the tire for investigation, in my o	ne, date ar pinion, dea	nd place, and due to the ath occurred at the time,	cause(s) a date and p	ind manner as place, and due	stated. to the cause(s)
١	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month	h, Day, Year)
			30. Name and address of person w	Jannery 30	2/0	Λ.	over	Shreet	Jan Baut	mary	25,2007 a1225
	Sta Registi		31. Date liled (Month, Day, Year)	32 Registrar's Sig		Social )					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yee **Physician** Vera Mae Ketterman 10:00 P February 2. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2020 Drummond Road Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖾 F Yrs 217-14-9847 Director 19,1922 84 Maryland Aug. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2020 Drummond Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or item any injury or other traumatic event, the Mental once. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 VNo Soecify. Š Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert T. Johnson Mamie Schultz ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert L. Ketterman, Sr.-Husband 2020 Drummond Road; Catonsville, Maryland 21228

20b. Place of Disposition (Name of Date 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 2/6/2007 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service License 23a. Part1. Effer the disease or complication, that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final -eukemia **Physician** disease or condition resulting in death) monte /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir The law requires thet the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 DNo Year Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy 1□ Yes No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 1 ☐ Yes 2 No this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) laiden Choia Girais 31. Date filed (Month, Day, Year) Begistrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician Moore Lee 01:45 29 2007 January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital NA Baltimore Date of Birth (Month, Day, Year) 11–12–1970 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 □ F 215-78-7630 Md. 36 **Director** Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 14 Yes 2 □ No Baltimore NA Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 716 E. 41st Street Funeral 14. Race · American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ☐ Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify. Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NA Disabled 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richardson Marcella Moore Gilbert မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 716 E. 41st Street, Baltimore, Md. Mother Marcella Moore 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Carmel Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or of
once. 2 Cremation 3 Removal from State Dundalk, Md. 2-5-07 ion 5 Other (Specify) 22. Name and Address of Facility Signatur March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 a . Enter the disease, or complications that caused the charh. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death med ate Cause (Final 3 days **Physician** Ineummia in death) /Medical Due to (or as a consequence of): Examiner Pulmmary Embolisa 2 weeks Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): year that initiated events resulting in death) Last and burial-tra Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as use 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 2 No 1☐ Yes 1 TYes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

2

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 5 2007

32. registrar's Signate of the Company of the C

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nexander MD



AT2438946

lanuary 25, 2007

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			Decedent's Name (First, Middle, La	st)					- Jouin		2. Date of De				3. Time o	of Death
	Physici		George M	Mueller							Month Februa	Di TOTA		Year 07	10.3	0 pm
	/Medic Examir		4a. Facility Name (If not institution, giv		oer)		4b. City	, Town, or	Location of	of Death	reprua	4	c. County o		110.50	o bu
	ZXX	٠.	2426 Dixie Lane				For	est I	7i 11				Harfo	rd		
	Funeral		5. Social Security Number 6. S		Age (In yrs.	last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h			lace (State	or Foreign
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	و <u>م</u>	}	Usual Residence of Decedent  10a. State 10b. County		100.0	ity, Town or Lo	nation							Τ.	Od Jasida (	Discol Limite
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	with t	Funeral Director	10e. Street and Number					p Code				_	itizen of W		itry :	
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	lter d	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Ford	es?		If Yes, spe	cify Cuba	n, Mexicar	, Puerto	Rican, etc.)			, White,		
336	irs af	by	3 X Widowed 4 ☐ Divorced	1 ⊠Yes 2 If Yes, Give Year or Dat	es: 1	944 945	1 🗆 Yes	2 <b>∑</b> No	Specify:				Specify:	Įv.	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or iteme 23a or 28a-f ehow ita Madical Exacilina casal ke nodified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usu	ial Occupa	ation			16b. l	Kind of Bus			
215	Hin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT L	ise retired	turing mos ')	t of worki	ng					
21	d wit	Š	10			Quali	ty C	ontro	ol En	gine	er	A	ero S	pace		
P	al Hy al Hy Toth	Be (	17. Father's Name (First, Middle, Last,						18. Mothe	r's Name	(First, Middle,	Maide	n Sumame	)		
Va	Ment	2	Joseph Mueller						Lou	ise	Davis					
Maryland	2 sho and is m		19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	or Rura	l Route Numbe	er, City	or Town, S	State, Zip	Code)	
	and ealth m 27		Colleen Holyhaus	(Daught		2426			ne Fo		Hill,					
ore	of H		20a. Method of Disposition  1 Daurial 2 Cremation 3	Removal from St		Place of Dispo cemetery, crea	natory or	me of other plac	Θ)		/6	20c. l	ocation - C	City or To	wn, State	
Ë	ment mant:	ļ	4 □Donation 5 □Other (Specif			st Holy	Red	eemei	Cem		007	Ba.	ltimo	re,	Maryl	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Iteme 23a or 28a-1 ehow empty or other traumatic event, it is Madical Examiner must be notified at ancilled.		21. Signature of Funeral Service Licer			22 F	2. Name a	nd Addres	ร of Facilit รว่า โรงม	y nera	l Home :	PΔ				
	40 ± • α		Muchael C. Ja	from 5			407	Old E	Caste	rn Av	venue :	Ess	ex, M	<u>aryl</u>		
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on ear	used the dea ch line.	th. Do not ent	er the mo	de of dying	g, such as	cardiac o	r respiratory ai	rrest,			Approxima Interval Be	etween
	Physician		Immediate Cause (Final disease or condition	, Ad	eNOG	ALCIWON	IN B	+1	UNG						Onset and	L
	/Medical Examiner		resulting in death)	Due to (o	as a conse	quence of):									7	
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	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	0) 01 600	r as a conse	quence or):										
	and and III-trar	Examiner	that initiated events resulting in death) Last	c	as a conse	quence of);										
8760,	cate be executed physicien and the burial-transit	dical E	(													
687	ficate g phy is the	0		u												
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									23d. Date	of delive	ery	
-	that the death certific ed by the attending p deteched for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnai	h 2∏Fet ntattime of∈		Ectopic p Other (s						Mon	th	Day	Year
P.0	by the	hys	9 Unknown	9□ Unknov	m 											
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	y P	Part II. Other significant conditions of	ontributing to dea	th but not re	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco	use contril	bute to th	ne cause of	death?
Records,	w require been sig should b	Completed by					_				1 197	es 2	2□No 3	3 🗌 Prob	ably 4 □	]Unknown
00	aw re	piet									24a. Was		24b. W	ere auto	psy findings	available
	The page	E									perfo	rmed? 2X N	de	ath?	2 □ No	Cause or
ita	artificant ctor,	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
<b>&gt;</b>	Physician: this certific ral director,	10	1 ☐ Yes 2 X No	Hospital: 1   Inj		] ER/Outpatier	nt 3 D	OA Othe	er: 4□ Nu	rsing Hor	ne 5 XResid	dence	6 □Othe	(Specif	v)	
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	f	28c. Injury Work	at c?	2	28d. Describe h	now inju	ury occurre	d		
sio	eath. or: A	ati	2 ☐ Accident investigation	1			М	10	Yes 2 🔲	No						
Division of Vital	ther d	Certification;	3 Suicide 6 Could not b	1 289. Place 0	f Injury - At h ,, etc. <i>(Sp</i> ec	nome, farm, str ify)	eet, factor	y, office		12	28f. Location (5 City or Tox	Street a vn, Stai	nd Numbe le)	r or Rura	l Route Nu	mber,
	urs al		<b>14</b>													
	To the Hoepital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exar	niner: On the bas	is of examin	owledge, deatl ation and/or in	h occurred vestigation	at the time, in my of	ie, date an pinion, dea	d ptace, a th occurre	and due to the e ed at the time,	cause(: date ar	s) and man id place, ar	ner as st nd due to	ated. the cause	(s)
	thin 2 the mple	Med	29b. Signature and title of certifies	and manne	r stated.		29	c. License	number			29d D:	ate signed	(Month	Day Year)	
	F ₹ ₹ 8		1. n. A No	Dea- K	1.0		1	120	167:	72	-		_	-		
/	x		30: Name and address of person who	momple and	of death (t)	m 22c) /T:=	Driet'	1001	01	00	C	V	-	7)		
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	Sta	te	31. Date filed (Month, Day Year)	32. Re	strar's Sign		6-			1						
	Registr		FEB 0 5	2007	Pagees .	K.	Derman	10								

Physician /Medical Examiner

**Funeral** Director

To Be Completed by Funeral Director

Registrar				•	tment of I ificate of				Reg. I			
I. Decedent's Name (First, Middle, L.	ast)							2. Date of D	eath			3. Time of Death
TOMEKAR A. MATI	THEWS							Month JANU	4 4	285	2 <i>00'</i>	117:30A
a. Facility Name (If not institution, gi	ive street and nu	mber)	A >		4b. Cily, Town, o	or Location of	of Death			4c. County	of Death	
SI AGNES	HOS	PII.	AL		Balti	MOR						<u>-</u>
,	Sex 1 □ M 2 1 F	7. Age (In y 22			If Under 1 Year Months Days	If Under Hours	Min.	8. Date of B	ay, Yea		Cou	nplace (State or Fore untry)
579-13-0389  Usual Residence of Decedent								SEPT.	1,	1984]	TKTI	NIDAD, VI
10a. State 10b. County		10c.	City, Town	n or Loca	ition							10d. Inside City Lim
MARYLAND		F	BALTI	MORE								1 X Yes 2 □
10e. Street and Number					10f. Zip Code					Citizen of W	hat Cou	untry?
26 CANWICK COURT	T 40 Was Das			10.144	2124				_	.S.A.	4.24	
<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Dec Armed Fo 1  Yes	orces?	n U.S.	13. vva	as Decedent of I Yes, specify Cub	Hispanic Ori an, Mexicar	gin? (Sp n, Puerto	ecity Yes or in Rican, etc.)	10-		e - Amer k, White	rican Indian, e, etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ive		1 [	□Yes 2ሺ No	Specify:				Specify.	BLAG	CK
15. Decedent's E	Education		16a.	Deceder	nt's Usual Occup	pation	· - 4	·-=	16b.	Kind of Bu		
(Specify only highest gi	College (		-	life. DC	nd of work done O NOT use retire	during mos d)	t of work	ing				
	5			HEA	D TELLE					ANK		
17. Father's Name (First, Middle, Las	<i>t</i> )							First, Middle			e)	
STEVE JOSEPH	China Orine)		10h	*******	111 (Ctural	1		S. MAT				
19a. Informant's Name/Relationship		/ משווייי		_	Address (Street							
CLAIR A. LEWIS ( 20a. Method of Disposition	GRANDINO	/	b. Place of	f Disposit	6 HILBU! tion (Name of	1		L. ALBA Date	-			Z Town, State
1 X Burial 2 ☐ Cremation 3 I		State	cemeter	ry, crema	tory or other pla  D CEMET		2/3/					
'4 ☐ Donation 5 ☐ Other (Spec 21. Sign ture of Funeral Service Lips		PI	KING	-	D CETET:	LJICI			Ų	UEENS	, 141	Y
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shock, or heart failure. List only	y one cause on a	each line.			the mode of dyi	ng, such as				MI, 0 ;	1	
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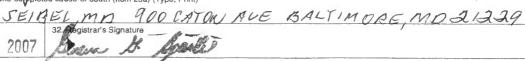
State Registrar

DHMH 17 Rev 1/2001

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Date filed (Month, Day, Year) FEB 0 5 2007

TEFFREY



07-00514 Roy D. Miller

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oy D. Willion		- For State Criticate of Death Registrar	Reg.	No. 200	7 02121
Physicia	n/	Decedent's Name (First, Middle,Last)	Date of Death     Month     D	ay Year	3. Time of Death
ledical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	January 19,	4c. County of Dea	
		Union Hospital Elkton		Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(	MM/DD/YYYY) 9 B Fore	ign
Director		1 VM 2 F 37 Yrs.	Feb 3	1479 0	country) MO
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d, Inside City Limits
ž . l	_	North East			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number  North East 10f. Zip Code	10g.	Citizen of What Co	untry?
th the Maryland 23a or 28a-f sho notified at once.		101 Beech St. 21901		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Never Married 2 Married Armed Forces? 14. Was Decedent of Hispanic Origin? (Sp. 15. France) If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	erican Indian, Black,
ter dea ", or ii er mus		3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 No specify:		Specify:	white
hours af "natural"	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life DO NOT use retired.)		6b. Kind of Business	s/Industry
6 n 72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		C	
within giene her the Med	mo -	17 Father's Name (First, Middle, Last) Cartenty	(First, Middle, Ma	iden Surname)	mtv .
21215-0036 Juld be filed within 72 Mental Hygiene marked other than 'e event, the Medical					
e, MD 21215-00.  I and 2 should be filed with Health and Mental Hygiene Titem 27 is marked other to remain to event, the Meet					
ore, MC es 1 and 2 sh of Health an If item 27 her trauma	-	Debra Miley Inother 101 Beech St No. 20a Method of Disposition.  20b. Place of Disposition (Name of cemetery.	Date Date	20c. Location - City	algal or Town, State
imore, MD 2 Pages 1 and 2 shou ment of Health and I tant: If item 27 is n or other traumatic		1 Burial 2 Cremation 3 Removal from State crematory or other place)	ł	ŕ	
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	-	4 Donation 5 Other Specify: Metro cremotory 3 = 21. Significantly Funeral Service Liquids Service 22. Name and Address of Facility	2-07	Batto, m	ID
Ba perm Depa Imju	- 1	1 Amol 1 hand TIAM 1232 Midall	ley Dr.	JESSUPI	PA8439
Physician		23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of fallure. List only one cause on each line.	r respiratory arresi	, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)  a. Complications of methadone intoxication  Due to (or as a consequence of).			Death
		Sequentially list conditions,  b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
760, icate be executed physician and the burial - transit	_	d,			
so, ie be e: ysiciar burial	Medica	AMENDED #23a,PII,27,28a-f, perME, g864, 2/6/0	7 TT	23d. Date of delive	erv
3876 rtificat ing ph as the		23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	ancy	Month	Day Year
Box 68760 : death certificate b the attending physical for use as the bu	Physician	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown			
that the de led by the detached i		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
P.O.	d by	Benzodiazepine use	1 Yes	2 No 3 P	robably 4 🗸 Unknown
ords,	olete		24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
ul Recc m: The lav rrifficate ha	Completed		perform 1 <b>Y</b> es 2		
tal Rection: The certificate ector, page	Be	25. Was case referred to medical examiner? 26. Place of Death (Check Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 Nursing	<del></del>		
Physical directions	은	examiner? 1 Yes 2 No  Hospital 1 Inpatient 2 ER/Outpatient 3 DOA  Other 1 Nursin  27. Manner of Death  28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	-	esidence 6 Oth	ner:
Division of Vital Records, tal or attending Physician: The law requir is after death.  al Director: After this certificate has been seen in the funeral director, page 2 should the fine than the funeral director.	tion	1 Natural 5 Pending Find 1/17/2007 Find 7:16 pm 1 Yes 2 X No	unknown		
ViSic or Atte fter des Directo	ifica	Accident Investigation 28e Place of Journa, At home farm street factory office huilding etc.	28f Location (Str	eet and Number or	Rural Route Number, City
Div Hospital o 24 hours af Funeral D	Certification:		_	te) MD 101 W.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the cause at the time, date ar	s) and manner as sind place, and due to	tated the cause(s)
To the I within 2 To the I complet	Med	29b. Signature and title of certifier / 29c License number		29d. Date signed (I	
		(in y of Hallow O.C.M.E.		January 20, 20	07
		30. Name and address of person who completed cause of death (Item 23a)	14		
	.0 6	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120  31. Date filed (Month, Day, Year) 32. Spistrar's Signature.	71		
St Regis	tate trar				

			For State Registrar	State o	f Maryland		artment rtificate				-	gienė Reg. No.	007	031	21
	Dharaini		1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month		Year	3. Time of	Death
	Physici /Medio		Dorothy	I.		Ma	ce				Februa	ry 2,	2007	1:28	AM
	Examin		4a. Facility Name (If not institution	-	mber)		, ,		Location	of Death		4c. Co	unty of Death	1	
			Joseph Richie H					ltim					N/A		
	Funeral		5. Social Security Number 214-05-1838	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. las		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth	place (State ontry)	or Foreign
	Director		Usual Residence of Decedent		86	TIS.					February	7 2 <b>,</b> 192	Mar	yland	
	and		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside C	ity Limits
	Many f eh	ō	Maryland Anne A	rundel		Sever	na Pa	rk						1 🗌 Yes	2 <b>X</b> No
	288	rec	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	untry?	
	3a o	<u> </u>	307 Riverdale D	rive				2114	16				USA		
	deetl	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.S.	. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	14.	Race - Amer		
ဖွ	or Its	F	1 Never Married 2 Marr	ried 1 ☐ Yes	2X No	1	1 ☐ Yes 2		Specify:		ricari, etc.)		Black, White ecity: Whi		
8	hours efter deeth with the Maryland tural', or Items 23a or 28a-f ehow al Examiner must be notitled at	d by	3X Widowed 4 □ Divorced	Year or D	ates:			~							
7	72 h "nati	Completed	15. Deceden (Specify only highe	it's Education st grade completed)		16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation during mos	t of work	in <i>g</i>	16b. Kind	of Business/li	ndustry	
12	within ene. then "	du	9 years	College (	1-4or 5+)		eteria					S+ N	iary! c	County	7
20	Hygie ther ant,		17. Father's Name (First, Middle,	Last)	1	Cal	ererre	a wc		er's Name	First, Middle			Country	
ılanı	uld be Mental riked o	To Be	John Charles Ho								ene Duva		,		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at once.	i q	19a. Informant's Name/Relations Virginia Majors		er						ndalk,			ip Code) 21222	
	s 1 and f Healt Item 2 other		20a. Method of Disposition		20b. Pla		sition (Nam				oate uary		ion - City or T		
Baltimore,	Peges iment of tant: If It jury or o		1 ∑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	Glen	Have	n Mem	oria	ıl	7, 2	2007		Burnie		
Balt	permit. Departimontal		21. Signature of Furieral Service	Licensee		7	onnel.	ly F	unera ers Po	al Ho Sint	ome Of 1 Road, 1	Dundal Dundal	k,P.A. k,MD.	21222	
2/2/07	been signed by the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enibrate disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to an ineutate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	or as a conseque	ence of):	ia							Approximation interval Bel Onset and UNK N. 6	tween Death
A C € .0. Box 6	I the death certifica by the attending ph ached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐Live t	come of pregnand wirth 2 ☐ Fetal disant at time of dea own	leath 3[	Ectopic pre					230	. Date of delin Month	•	Year
Sp.	equires that sen signed b	d by P	Part II. Other significant conditions COYO Wary a	1	eath but not result	ting in the u	nderlying ca	iuse give	en in Part I	•		obacco use Yes 2□N		the cause of o	
+ + + V	The lay	Completed									24a. Was auto perio 1 Yes	psy prmed2	4b. Were aut prior to d death? 1 ☐ Yes	opsy findings ompletion of o	available ause of
+ita	iding Physicien; th. : After this certifics funeral director, p	Bec	25. Was case referred to medica examiner?		10000			_	26. Place	of Death	Check only	-		-11	_
0 -	hysic his ce Il dire	2	1 ☐ Yes 2 No			R/Outpatier	nt 3□ DO	A Othe	er: 4 □ Nu		me 5 Resi		her (Spec	(N) +05	rice
م <del>د</del> ه	ing P	ë.	27. Manner of Death  1. Natural 5 □ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		Bc. Injun Worl	k?		28d. Describe	how injury o	ccurred		
Sio	Attending r death. Actor: Afte by the fune	catl	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be	111		M		Yes 2□						
Dora	at or At after of Direct d in by	ertifi	4 Homicide determ	nined 200. Flace	of Injury - At hom ng, etc. (Specify)	ne, farm, sti	eet, factory	, office			28f. Location ( City or To	Street and N wn, State)	lumber or Rui	ral Route Nun	iber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical Certification:	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the b and man	best of my knowl asis of examination ner stated.	ledge, deat on and/or in	h occurred a vestigation,	at the tim in my of	ne, date an pinion, dea	nd place, ith occurr	and due to the ed at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s	s)
	To ti To ti	Σ	29b. Signature and title of certifie	ar .			29c	License	e number			,	igned (Month		
			25	(IM o				72	417	0		Feb	ruary:	2, 2ec	57
i	3		30. Name and address of person	who completed caus	se of death (Item 2	23a) (Type,	Print)	J. R	alti	Mor	R. M	カフェ	ruary 2 201		
	Sta Registi		31. Date filed (Month, Day, Year,	2007	egistrar's Signatu	ire /or	all!				-/-				
			FEDVU	LUU!		-									

07

07-00732		Please Type or Print in Black Indelib State of Maryland / Departmen	le Ink. Ensure All Copie	s Are Legit	ole.				
Elizabeth Ann Mo	1	For State Certificate	e of Death	rgiene Reg 1	vo. 200	7 0312			
Physicia Medical Examin	n/	eqistrar   Decedent's Name (First, Middle,Last)   Elizabeth Ann Moor		Date of Death     Month Da     January 26, 2	av Year	3. Time of Death 0720 hrs			
(		ta. Facility Name (if not institution, give street and number)  17 Valley Arbor Court B	4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore Cou				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth(N	MM/DD/YYYY) 9. Birt Foreig				
	-	Usual Residence of Decedent	Yrs.	Sept. 11	,1909   000	10d. Inside City Limits			
nd show any ice,		MD Baltimore 10c. City, Town or Essex	Location			1 Yes 2 X No			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e Street and Number 17 Valley Arbor Court #B	10f. Zip Code 21221	10g.	Citizen of What Cour	ntry?			
th with the rems 23a	— L	11 Marital Status 12. Was Decedent Ever in U.S. 1 1 Never Married 2 X Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri White, etc.	can Indian, Black,			
after dea	by Fur	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	and done 16	Specify: Whi				
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "matural" natic event, the Medical Examiner.			cedent's Usual Occupation (Give kind of v ring most of working life. DO NOT use reti		D. KIIIO OI BUSIIIESS/I	Houst y			
5-0036 iled within 7 Hygiene. I other than	Completed	12 Home	emaker 18.Mother's Name	(First, Middle, Maio	Own Home den Surname)	<del></del>			
21215 vuld be filt Mental H marked o	a	Elmer John Scanlon  19a. Informant's Name/Relationship (Type, Print )  19b. I	Elizabet  Mailing Address (Street and Number or R	h A. Mill Rural Route Numbe		, Zip Code)			
MD 2 should the and M 27 is reaumatic	٦į	Raymond E. Moor/husband  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery.)  Date  20c. Location - City or							
nore, ages I an nt of Hea t: If iter other tr		1 Burial 2 Cremation 3 Removal from State cremator	eltsville						
Baltimore, MD 2: permit. Pages I and 2 should Department of Health and M Important: If item 27 is minjury or other traumatic e	ij	21 Signature of Funeral Service Licensee	cake Crematory 01/ Going Home Cremation	on Servic	e P.O. Bo	ox 784			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		r respiratory arrest	Clarksvil shock, or heart	between Onset and			
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Complications of para	plegia			Death			
1	Jer	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):							
ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
e executed cian and rial - trans	ical	UNPENDED AMENDED #23a,PII,27,28a-f.	perME. 2864. 2/20/07 TT	···					
P.O. Box 68760, es that the death certificate be executed igned by the attending physician and be detached for use as the burial - transit	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	ancy	23d Date of deliver Month	y Day Year			
Box (e death ce the attence of for use	Physici	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Unknown	Other (Specify)	22a Did taha	acco use contribute to	the sause of death?			
Division of Vital Records, P.O. B. vitin 24 the Hospital or Attending Physician: The law requires that the de within 24 hours after death To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting  Diabetes mellitus; chronic pneumonitis	in the underlying cause given in Fact.		2 No 3 Pro	bably 4 Unknown			
of Vital Records, ng Physician: The law requir After this certificate has been si meral director, page 2 should b	ompleted		_	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of			
al Rec nn: The prificate tor, page	O	25. Was case referred to medical	26.Place of Death (Check	1 Yes 2	No 1 Y	es 2 No			
f Vita Physicia er this ce	To B	1 Ves 2 No	tpatient 3 DOA Other Nursi	•	esidence 6 🗸 Othe	ouse fire and			
ion o itending leath tor: Aft	ation:	1 Natural 5 Pending (Month, Day, Year) 2 X Accident Investigation unk unk	1 Yes 2 X No	jumped fro	om second fl	oor			
Division ital or Attendii urs after death ral Director: A	Certification:	2 2 1 Accident							
he Hosp in 24 hou the Fune	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check only one) Physician: To the best of my knowledge, deat one) Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the cause( at the time, date an	s) and manner as stand place, and due to t	ted ne cause(s)			
To with To com	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Me				
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		January 26, 200				
		Ana Rubio MD. Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 2120	)1					
S	tate	25	Secretics.						

ORIGINAL

		•	For State Registrar	State of Maryla		artment of Hertificate of E			ene g. No.2 0 0 7	03123
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Melvina Ruth 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of De	January	19, 2007 4c. County of Dea	1:37 P M
	Examin	er	Civista Medical				Plata	aut	Charl	
	Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Birth	Year) 9. Bir	thplace (State or Foreign ountry) St Virginia
	Director		235-36-5865	M 2⊠F 86	Yrs.	Months Days	110013	n. 8. Date of Birth (Month, Day, April 13	, 1920 Wes	st"Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary I eho	tor	Maryland Charle	es	LaP1a	ta				1 X Yes 2 □ No
	or 28a	lirec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	ath will	Funeral Directo	137 Huckleberry D			2064			U.S.A.	
	er der Iteme	une	Tr. Markar Olaros	12. Was Decedent Ever in Armed Forces?	n U.S.   13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whi	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:		Specify: W	hite
21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or iteme 23e or 28e-f ehow than "naturel", or iteme 20e or 28e-f enow he Madical Examinar must be notified at	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa kind of work done d	ition	orkina 1	6b. Kind of Business	/Industry
21	fwithin 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	, , , , , , , , , , , , , , , , , , , ,		10.0	
121			17. Father's Name (First, Middle, Last)	1		Clerical	18 Mother's N	ame (First, Middle, M	US Governn Jaiden Sumame)	nent
Maryland	S is b	To Be	Teddy C. Summers					Jane Arms		mers
ary	2 should and Men le marke aumatic	F	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Street a		Rural Route Number,		
	rt 2 mg		John R. Moore/Son		137	Huckleber	ry Driv	e, LaPlata		
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		natory or other place			Oc. Location - City or	
ij	permit. Pages Department of importent: If it in injury or o		4 ☐ Donation 5 ☐ Other (Specify)	Be						West Virgini
Bal	Department Department		21. Signature of Funeral Service License	9M00053		Name and Address			d Washingt , Maryland	
ı			23a. Part . Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the die cause on each line.					7 4	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	JOV PONCYU		MOTEC!	THUD	IN BOW	CAR DR	acse years
	Examiner			Due to (or as a cons	sequence of):	win.				Hunry
		Jer	if any, leading to immediate	Due to (or as a cons	sequence of):					
	t be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. Uro	SKERS	<u>T</u> 2.				Hours.
,092	oe exe		resulting in death) Last	Due to (or as a cons	sequence of):					
687	cata b	dicai								
Вох 6	leath certificata t ettending physic I for use es the b	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre					23d. Date of de	livery
	The law requires that the death certificata be executed as bean signed by the ettending physicien and bage 2 should be detached for use es the burial-transit	Physician/Med	in the past 12 months?	1 Live birth 2 ☐ F		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the e detached f	Phys	9 Unknown	9□ Unknown						
	ires tha signed d be del	ρ	Part II. Other significant conditions cor	itributing to death but not	resulting in the u	nderlying cause give	on in Part I.	23e. Did tob		o the cause of death?
Š	w require been si should I	etec						24a. Was ar		
of Vital Records,	The law	Completed						autopsy perform	prior to death?	utopsy findings available completion of cause of
tal		0	25. Was case referred to medical				26. Place of D	1 ☐ Yes 2	No 1 Yes	s 2 No
Ţ	S & 5	To B	examiner? 1 ☐ Yes 2 🗷 No	ospital: 1 Unpatient 2	2 ☐ ER/Outpatier	nt 3 DOA Othe	ac.	Home 5 Reside		ecify)
	ding Ph h. After th funeral		27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o	Work	at ?	28d. Describe ho	w injury occurred	
sio	tendi Jeath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be	One Place of Laives A	It have form at		/es 2 □No	28f. Location (Str	eet and Number or R	hural Davida Mumbar
Division	tal or Attendi rs after death. al Director: A ed in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.		еет, тастоту, оптсе		City or Town		urai Houte Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier 1 Check only one) 1 Medical Exemit	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the tim vestigation, in my op	e, date and pla pinion, death of	ice, and due to the ca curred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the comple	M	29b. Signature and title of certifier	10x	Rar	29c. License	number	629	d. Date signed (Mon	th, Day, Year)
	0		30 pame and address of person who co	impleted cause of death (	M	W. C.	DLO:	ror, v	~ Q 21	0603
5	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	arki				
DH	Regist		FEB 0 5 20	07 Alexander	J. 19					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Flat Amend #1Per Phy &7&8 Per FH G864 2/05/07 JH Registrar 1. Decedent's Name (Fire Middle tart) 2. Date of Death January 29 2007 **Physician** 4:07 A M Lillian Vernell Maclin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. Seep p col 1934.

Months Days Hours Min. (Mack Day Pear) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Virginia 1 □ M 2 □ F 230 38 9445 81 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at 1√Yes 2 No Director Baltimore Marvland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 2 White Law Place Apartment T-C Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 XNever Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Black 2 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 sho, id be filed wn Department of Health and hental hygien Important: if item 27 is marked other the any injury or other traumatic event the Computer Specialist Computer Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Maclin. Sr Maggie Rives ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Maclin 2 White Law Place Apartment T-C Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Little Church Street Cem. February 2 2007 Petersburg, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home Inc 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Angrene veeks /Medical Due to (or as y consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner d any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transi and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? for Month Year 5 ☐ Other (specify) P.O. I signed by the aid be detached detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, δ. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 2 No 2 3 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) +ospice 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Sta

State Registrar 31. Date filed (Month, Day, Year) 22. Regis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMC



MO

DHMH 17 Rev 1/2001

N. Charles St. Bolto, Md 21204

Jonuary 29, 2007

			Please	Type or Prin							_	
			For State Registrar	State of Ma	ryland /	Department Certification			Mental Hy	/giene Reg. No	0000	00105
É	Physici	an	Decedent's Name (First, Middle, La	-	BRIL				2. Date of D Month			3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, giv				, Town, o	or Location of Deat	102 h	40	County of Death	9 ' 1 -
.m.15	Funeral		5. Social Security Number 6. S		(In yrs. last I	birthday) If Under	r 1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D	rth	9. Birthp	place (State or Foreign
b	Director		220-20-2066 Usual Residence of Decedent	₩ 2□F	78	Yrs.	Days	TIOUIS WIII.	02-03-20	07	Maryl	and
	Maryland standard	lor	10a. State 10b. County Ba	Itimore	10c. City, To	Parkville						10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a- be notif	Funeral Director	10e. Street and Number 2605 Proctor Lane			10f. Zi	p Code	1024		10g. Ci	tizen of What Cou	ntry?
	leath v	erai	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Dece		.234 Hispanic Origin? (Span, Mexican, Puer	Specify Yes or N	0-	U.S.A. 14. Race - Americ	can Indian,
920	should be filed within 72 hours after death with the Maryland nd Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show marked other than "natural" or items 23a be possible and a matic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	Armed Forces? 1 [X] Yes 2 □ N If Yes, Give Year or Dates: K		If Yes, spe			to Rićan, etc.)		Black, White,  Specify: Whit	
5-0	"natur edical	leted	15. Decedent's Ed (Specify only highest gra		16	ia. Decedent's Usu (Give kind of w	ial Occup ork done	pation during most of wo d)	rking	16b. K	(ind of Business/In	dustry
21215-0036	d within giene. er than the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Inspecto		<u>.                                    </u>		Bal	timore Gas	& Electric
and	should be filed wind Mental Hygies marked other tumatic event, th	Be	17. Father's Name (First, Middle, Last Daniel J. McBri					18. Mother's Nar	<sup>me (First, Middle</sup> garet Far		n Surname)	
, Maryland	d2 tha 7 Is	To	19a. Informant's Name/Relationship (Daniel J. McBride,		1!	9b. Mailing Addres 2605 Pro		and Number or R		ber, City	or Town, State, Zip	o Code)
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		of Disposition (Na tery, crematory or and Memoria		1	Date 6_2007		coation - City or To	
altin	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 ☑ Other (Special 21. Signature of Funeral Service Kilce)	7	Inoreid	22. Name a	nd Addre	ess of Facility	6 <b>-</b> 2007 5305 Н	arfor		
œ	9 9 E # 9		23a Parti Enter the disease or com	plications that caused	the death D			Ruck, Inc.			Maryland 2	1214 Approximate
	Physician		23a. Part 1. Enter the disease, or com shock, or heard dilure. List only Immediate Cause (Final disease or condition	one cause on each line	BARLA	= Ar	174	- M40	CARY	PiAI	IN FAV	Interval Between Onset and Death
**	/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):	4/			1110		C/1621
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	e of):	10	7		-		
oʻ	e executed ian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence	e of):	1171	/		<u> </u>		
	cate be physicia the bur	dical	•	d								
Box 6876	The law requires that the death certificate be ate has been signed by the attending physicis page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal dea			:y			23d. Date of deliver	ery Day Year
P.O.	at the d by the stached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown								
rds,	quires the signed and be de	ģ	Part II. Other significant conditions	contributing to death bu	t not resulting	in the underlying	cause giv	on in Part I.				he cause of death? bably 4 ⊠Unknown
Division or Vital Records,	e law requir has been si e 2 should l	Completed	HYPERLIA	PIDEMI	1					psy	prior to co	opsy findings available impletion of cause of
ta	sician: The law s certificate has b irector, page 2 s	Be Cor	25. Was case referred to medical					26. Place of De	1□ Yes	ormed?	death? 1 □ Yes	2 No
or V	Physici this cer al direc	은	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur		Outpatient 3 D	UA	ner: 4X Nursing I	lome 5□Res	idence	6 □Other (Specia	fy)
ion	Attending Physician: It death. ector: After this certification by the funeral director,	ation	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day		Injury M	28c. Inju Wo 1 □	rk? ]Yes 2∐No	28d. Describe	ritow inju	iry occurred	
Divis	al or Attendated after death	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, . <i>(Specify)</i>	farm, street, facto	ry, office		28f. Location City or To	(Street a. own, Stat	nd Number or Rura e)	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination	lge, death occurre and/or investigation	d at the ti	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s	s) and manner as s nd place, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	112 -0	· ·		2 (	se number			ate signed (Month,	
7	11 -		30. Name and address of person who	completed cause of de	eath (Item 23a	A) (Type, Print)	24	648		02	03-	2007 E 21218
1	1-4		SHER A HAS.	HM) MC	139 r's Signature	n LOC	HI	CAVEN 9	SUD	BA	LTIMOR	E 21218
	Sta Registi		FEB 0 5	2007 Deser		Chests	9					

07-00783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

add Miller		State of Maryland / Departmen I-For State Certificate Registrar		giene <sub>Reg</sub>	.No. 200	7 0312
Physician Medical Examine	-	1. Decedent's Name (First, Middle,Last)			Day Year	3. Time of Death 0830 hrs
- Lamine		Ladd E. Miller  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	January 28,	4c. County of Death	
		1000 Franklin Ave #610	Essex		Baltimore Cou	anty
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24Hrs. Months Days Hours Min.  Yrs.	8. Date of Birth  8 - 7 - 1 9	(MM/DD/YYYY) 9. Bir Foreig 9 3 9	
any	-	Usual Residence of Decedent           10a State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
<b>*</b>	5	MD Baltimore Essex				1 Yes 2 X No
death with the Maryland or items 23a or 28a-f sho must be notified at once	- 1	1000 Franklin Ave., Apt. 610	10f. Zip Code 2 1 2 2 1	Ţ	J. Citizen of What Cou J.S.A.	ntry?
	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri  Yes 2 No specify:		White, etc.	rican Indian, Black,
ours afte	اۋ	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation (Give kind of wor		Specify W1 16b. Kind of Business/	lite Industry
nore, MD 21215-0036  ages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene.  tt: If item 27 is marked other than "natural", other transmite event, the Andical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use retired	d)	Camp	
-003 d within giene. ther th	Ĕ	17 Father's Name (First, Middle, Last)	Carpenter 18.Mother's Name (F	irst Middle Ma	Carpe	entry
215. be filed ntal Hy rked of	Be C	Walter Miller	Alice C	hatter	cton	
should is man		19a Informant's Name/Relationship (Type, Print ) 19b. M	ailing Address (Street and Number or Run	ral Route Numb	er, City or Town, State	
and 2 sealth a tem 27	-	Ruth Miller - Wife 10 20a Method of Disposition 20b Place of D	00 Franklin Ave,	Apt.	610, Ess	Sex, MD
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Bygiene. Important: If item 27 is marked other than anjury or other transmitte event, the Connection of th		1 Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:	or other place) w Crematory 1-3	1-07	Baltimor	re, MD
Balt permit. Departi Importinjury	Į		22. Name and Address of Facility Bra PA, 2134 Willow	dley-A	Ashton Fu	neral Hom
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not en failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple injuries	nter the mode of dying, such as cardiac or n	espiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
Sxaminer		or condition resulting in death)  Due to (or as a consequence of):				1
	힐	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				+
	ami	Due to (or as a consequence of):  C.  Due to (or as a consequence of):  AMENDED  #23a,27,28a-f,  IF FEMALE:  23b, Was decedent pregnant in the				-
cuted ind transit	ă	d				
be exe sician a	ğ	X UNPENDED #23a,27,28a-f,	perME, g864, 2/12/07 TT			
Sox 68 death certif	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   2   4 Pregnant at time of death   5   9 Unknown   9 Unknown	Fetal death 3 Ectopic pregnand Other (Specify)		23d. Date of deliver Month	Day Year
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S, P puires t puires t puires t	ed b		,	1		bably 4 Unknown
cord	Completed			24a Was ar autopsy perform	y prior to	utopsy findings available completion of cause of
Re(		25 Was case referred to medical	26 Place of Death (Check on	1 <b>✓</b> Yes 2		es 2 No
Vital vsician vsician nis cert directo	Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpate			tesidence 6 🗸 Othe	er: Scene
of on mg Phy	입	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tim			ow injury occurred	
Sion Attendi death. ctor:	읉	Pending 2 Accident Investigation 1/28/2007 Fnd 8	اللك لكه ا		mped from ba	
Division of Vital Records, P.O. In the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification:	3 X suicide 6 Could not be determined (Specify) outside apartme	ent building     1	ssex, MD		ural Route Number, City Lin Ave.
To the Ho within 24 To the Fu	Medical	Check only one)  2 Medical Examiner: On the best of my knowledge, death one)  2 Medical Examiner: On the basis of examination and/or inversion and manner stated,				
F × 5 8	ĕ	29b. Signature and title of certifier	29c. License number	-	29d. Date signed (Mo	onth, Day, Year)
			O.C.M.E.		January 28, 200	7
07		Name and address of person who completed cause of death (Item 23a)     Mary G. Ripple MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, MD	21201		
Sta	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
Registr	rar	FEB 0 5 2007	Cooks			
DHMH 17 Rev 1/200	01	ORIG	INAL			

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland /	Department of F		ental Hygiene .Reg. No.	211117	03127
	Physici	an	1. Decedent's Name (First, Middle, Las				2. Date of Death Month Day	Year	3. Time of Death
	^/Medic	- 50	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	r Location of Death	4c.	County of Death	0.131
	Funeral		5. Social Security Number 6. Se	cal Center 7. Age (In yrs Last I	birthday) If Under 1 Year	MOVE If Under 24 Hrs.	3. Date of Birth (Month, Day, Year)	9. Birthr	place (State or Foreign
	Director		219-52-7282 11	DM 20 59	Yrs. Months Days	Hours Min.	Month, Day, Year)	47 ma	ryland
	ryland how Lat		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location	4.		1	10d. Hiside City Limits
	the Ma 28a-f s notified	Director	10e. Street and Number	IA	10f. Zip Code	male	10g. Citi	zen of What Cour	1. ☑Yes 2 ☐ No ntry?
	ath with 23a or rust be	ralDi	1213 Eth	ng St.	2	1217		US	SA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Maritál Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2☐ No	ispanic Origin (Specian, Mexican, Puerto R	ican, etc.)	14. Race - Americ Black, White, Specify:	etc.
215-0036	in 72 ho n "natur fedical	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working d)	16b. Ki	nd of Business/Ind	dustry
21	filed within Hygiene.		Elementary/Secondary (0-12)	College (1-4or 5+)	House	Keep	Pirst, Middle, Maiden	) mez	tic
land	2 should be filed and Mental Hygi is marked other aumatic event, tl	To Be	17. Father's Name (First, Middle, Last)	anning		Marga	ret S	mith	
Maryland	d 2 should th and Men 7 is marker traumatic		19a. Informant's Name/Relationship (7	Type. Print)  anning -Son	9b. Mailing Address (Street	and Number or R al	Route Number, City o	r Town, State, Zip	(Code)
	of Health		20a. Method of Disposition 1 ☐ Burial 2 Ocremation 3 ☐	20b. Place	of Disposition (Name of etery, crematory or other place	Da Da	ite 20c. Lo	ocation - City or To	own, State
Baltimore,	permit. Page Department Important: If any Injury of once.		4 □ Donation 5 □ Other (Specify  21. Sign are of Funeral Service Licen	, me	22. Name and Addre	ss of F-cility 2	07 1(a	tonsul	e, nd.
Ba	permit. Departi Importi any Inji		Mayyes m.	Chelace	nanco	n Wala	ce F. Son	ici Par	St. 10. md, 21229
· ·	32		23a. Park Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Firms)	olications that caused the death. Done cause on each line.	- A				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Out of as a consequence	u failure,	hyperk	aremia		acys
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68760 <del>0</del>	te be ex ysician e burial	edical E		d.	or org.				
	certifica ding ph se as th	/Med	IF FEMALE:	23c. If yes, outcome pf pregnancy				23d. Date of delive	env
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		у		Month	Day Year
Division or Vital Records, F	The law requires that the death certificate be executed tee has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Completed by P	Part II. Other significant conditions of	ontributing to death but not resulting	g in the underlying cause giv	en in Part I.		use contribute to the	he cause of death? bably 4 Unknown
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or/	Attending Physician: r death. ector: After this certification of the funeral director, i	은	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury 28b	Outpatient 3 DOA Oth b. Time of Injury 28c. Injury Wor	4 LI Nursing Hom	e 5 Residence		<i>(y)</i>
sion	tending leath. tor: Aft the fun	cation	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 🗆	Yes 2 □ No	N 1 10 10 1		
Divi	al or Al	Certification:	4 Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	, raim, street, ractory, onice		Bf. Location (Street an City or Town, State		ı Houle Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1. Certifying Ph 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	dge, death occurred at the ti and/or investigation, in my	me, date and place, a opinion, death occurre	nd due to the cause(s)	and manner as s d place, and due t	itated. o the cause(s)
	To th Within To th comp	Me	29b. Signature and title of certifier		29c. Licens			te signed (Month,	
	2		30. Name and address of person who	completed cause of death (Item 23)	a) (Type, Print) Paul Place	4666	Jun	uary 2	8,000
			Anita Tsen, u	32 Registrar's Standure	Paul Place	e Balt	more, 1	rayla	nd 21202
	Sta Regist		31. Date filed (Length, Dev. 5 2007	32. Registrar's Stonature	gearle				

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rian	C. Ni	do		State For State egistrar	e of Maryland		tment of ificate of		and I	Mental H		Reg. No	200	7 03128
edica	Phys al Ex		n/ 1	Decedent's Name (First, Middle,La  Marian  C.	Nido						2. Date of De Month February	Day	Year	3 Time of Death 1413 hrs
T. A.			4	fa. Facility Name (if not institution, given a Brett Court #215		r)	41	c. City, Tov Essex	n, or Lo	cation of Death	n		4c. County of Deat Baltimore Co	
	Fune Direc			5. Social Security Number 6. S	Sex 7. A	ge (In yrs. las	st birthday) Yrs.	If Under	Year Days	If Under 24Hrs Hours Mir	1.		M/DD/YYYY) 9. Bi Forei	irthplace (State or ign Pennsylvan ountry)
		ź.	ļ-	213–10–8376	IN ZAF	87	Town or Location	n .			9/15	9/ 19	19	10d Inside City Limits
	land	23a or 28a-i snow any notified at once.		Maryland Baltin	nore	Esse	ex.	407 7 - 0	-de			40- 0	William of What Co.	1 Yes 2 X No
	the Mary	a or 28a tified at	Direc	10e. Street and Number  2 Brett Court	Apt 215_			10f. Zip C			:		S. A.	anti y z
	filed within 72 hours after death with the Maryland I Hygiene	nust be no	- I	11. Marital Status 1 X Never Married 2 Marrie	12. Was Deceder Armed Force: 1 Yes		If Ye	Decedent s, specify (	of Hispa Cuban, N	Mexican, Puerto	pecify Yes or look Rican, etc.)			rican Indian, Black,
	ours after	atural,	2	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates: only highest grade co	ompleted)	16a. Decedent		cupation			16b	Specify: Wh	ite /Industry
036	ithin 72 h	marked other than "natural", c event, the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 o	or 5+)	Caret							ealth Care
21215-0036	2 should be filed within and Mental Hygiene	narked othe	Be Co	17. Father's Name (First, Middle, Las Angelo Nido	st)					Adelin	e (First, Middle a. [	DiGi	rolamo	
MD 21	sho	mati.	2	19a Informant's Name/Relationship		)				nd Number or Neck			City or Town, Statex. Marvl	te, Zip Code) and 21221
ore. N	es I and of Health	If item	1	20a. Method of Disposition  1 XBurial 2 Cremation 3		20b. P	Place of Disposi rematory or oth	tion (Name	of ceme	itery,	Date 2/7 2007	20	c. Location - City c	or Town, State
altimore.	permit Pag Department	Important: njury or o		4 Donation 5 Other Specifical Signature of Funeral Service Lice		Mos	st Holy	ame and A	ddress o	f Facility				, Maryland_
	hysic	ian	$\dashv$	23a. Part I. Enter the disease, of confailure. List only one cause on	mplications that cause	ed the death.	Do not enter th	07 OI ne mode of	d Ea dying, su	stern uch as cardiac	al Home Avenue or respiratory	Es arrest, s	sex, Mar	yland 21221 Approximate Interval Between Onset and
	/Med xami				a. Atheroscleroti			ease						Death
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a cor	nsequence of	T):		_					
	eq	and transit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of	r):							10 0
_	be executed	sician and burial - tra	edical	UNPENDED	AMENDED									
Boy 6876		ned by the attending phydetached for use as the b	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, oute  1 Live birth  Pregnant		2 Fe	tal death	3	Ectopic pregr	nancy		23d. Date of delive Month	Day Year
	the death	y the atte	Physic	1 Yes 2 No 9 Unknown	9 Unknown					ven in Part I.	23e. Di	d tobac	co use contribute t	to the cause of death?
٥	uires that	n signed by Id be detach	à								- 1 1 1 24a. W			robably 4 Unknown autopsy findings available
Oivicion of Vital Becords	ne law req	te has bee ge 2 shou	Completed								au	itopsy erformed	prior to	completion of cause of
2	cian:	his certificate has director, page 2 s	Be Co	25. Was case referred to medical examiner?	Hospital:				10	of Death (Chec	k only one)			
Š	g Physic	After this funeral dire	၉	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of I			at Work?	28d. Descri		injury occurred	ner Scene
9.00	Attendin death	ctor:	catior	1 V Natural 5 Pending 2 Accident Investig	g gation		ome, farm, stre	et factory		es 2 No	28f Locatio	n (Stree	et and Number or I	Rural Route Number, City
	spital or A	fille	Certification:	3 Suicide 6 Could n  4 Homicide determi	ined (Specify)						or Tow	n, State	•)	
	To the Hospital or within 24 hours afte	F 9	Medical	29a. Certifier 1 Certifying Physical Concept Control C	sician: To the best o ner:On the basis of e and manner stat	examination a	lge, death occu and/or investiga	tion, in my	opinion,	death occurred	nd due to the o	ate and	place, and due to	the cause(s)
	_	1	Ž	29b. Signature and title of certifier	re Shill.	/		29c.	O.C.N				ebruary 3, 20	
	2	1		30. Name and address of person wi	ho completed cause Assistant Medic			enn Stre	et, Ba	Itimore, <b>M</b> [	D 21201			
	-	S Regis	tate	31. Date filed (Menth, Pay, Year)	2007   194	strar's Signati	ure &	odi B						
_					A - 61/4/80		411,700	- Company of the Comp				_		

07-00925 Gerald Nellett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rald Nellett		State ( 1-For State Registrar	of Maryland /		artment of rtificate of		and	Menta	al Hyg		1. No.	0.0	7 0312
Physicia	n/	1. Decedent's Name (First, Middle,Last)								Date of Death		Year	3 Time of Death
edical Examir	ner	Gerald L. Nelle								Month February 2			1843 hrs
		4a. Facility Name (if not institution, give Mercy Hospital	street and number)		4	b. City, Tov Baltimo		ocation of I	Death		4c. Cou	nty of Dea	th
Funeral Director		5. Social Security Number 287–34–5997 6. Security Number 1287–34–5997	7. Age	e (In yrs. I 64	ast birthday) Yrs.	If Under	Year Days	If Under 2 Hours	24Hrs. Min.	8. Date of Birth 06/22/		Fore	rthplace (State or gn OH ountry)
		Usual Residence of Decedent											
nd show any	١	OH 10b. County Wood	Ē	10c. City,	Town or Location		ssfo	rd			10d. Inside City Limits  1 X Yes 2 No		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number 545 Indian Ridge	R Trail			10f. Zip Co		3460		109	g. Citizen o	What Cou	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1 Yes 2 X No specify:  S							Vhite, etc.	merican Indian, Black, c. <b>White</b>				
urs af tural	a p	15. Decedent's Education (Specify onl	or Dates:	pleted)	16a. Decedent	s Usual Oc	cupation	n (Give kir			16b. Kind o		/Industry
036 ithin 72 ho ne. r than "na ledical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)		st of workir .ectri	_		se retired	1)	I	Elect:	rical
1215-0 the filed wental Hygie orked othe	Second Second												
MD 2' d 2 should lth and Mi n 27 is ma	입	19a. Informant's Name/Relationship (Ty Angie Rumer / Dan			19b. Mailing 81 Rc	Address (	Street a	ive,	er or Rur <b>Apt</b>	al Route Numb	er, City or ROSSFC	rown, Stat	e, Zip Code) OH 43460
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a Method of Disposition  1 Burial 2 Cremation 3 2  4 Donation 5 Other Specify:	Removal from Sta	ato.	Place of Disposi crematory or oth stlawn Men	er place)				7/2007		_	r Town, State
Balt permit Departi Importi injury		21. Signature of Funeral Service Licens	- March	all	22, N Cha 150	ame and Ac rles )1 Eas	L. L. St F	Steve	ens Aven	Funeral ue, Bal	Home	Inc e, M	D 21230
Physician /Medical Examiner		23a. Part I. Enter the disease, or complifailure. List only one cause on each immediate Cause (Final disease a. A.					dying, su	uch as car	diac or re	espiratory arres	st, shock, o	r heart	Approximate Interval Between Onset and Death
Adminer			oue to (or as a conse	equence o	of):							-	
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse										
50, te be executed system and burnal - transit		d_	Oue to (or as a conse										
be exe	edical	UNPENDED	AMENDED 10	e,g p	er fh g	864 2	-5-(	)7 <b>v</b> t					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon  1 Live birth  Pregnant at		2 Fet	al death	3 [	Ectopic p	oregnanc	y	23d. Dat Mont	e of delive h	ry Day Year
. Bo)	hysi	Part II. Other significant conditions	9 Unknown					- i- B-d		Logo Did tob			o the cause of death?
S, P.O.  Lires that the signed by d be detach	ğ		contributing to death	Tout not i	esciting in the di	idenying ca	ause giv	erimran	1.				obably 4 Unknown
Division of Vital Records, P.O. End or attending Physician: The law requires that the distributed ceath.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	ompleted							<del></del>	_	24a. Was an autops perform	y ned?	prior to death?	nutopsy findings available completion of cause of
al R	Be C	25. Was case referred to medical examiner?				26.		f Death (C	heck on				
of Vital Rec ling Physician: The I After this certificate I funeral director, page		1 <b>Y</b> es 2 No			ER/Outpatient						Residence		er:
27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No													
The string of th									tural Route Number, City				
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of m On the basis of examination and manner stated.										
F 3 F 8	Me	29b. Signature and title of certifier	/ v				icense						onth, Day, Year)
		30. Name and address of person who co	ompleted cause of d	) leath (Item	n 23a)	(	D.C.M	.E.			Februar	y 3, 200	97
10			Assistant Medi	,	,	l Penn S	treet,	Baltimo	re, ME	21201			
St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure -	1 May 10							

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	aryland		rtment of H		lental Hy	giene	000	00100
	_		Registrar			Cer	tificate of L	Death	1	Reg. No.	100/	03131
	Physicia	an	1. Decedent's Name (First, Middle, L	asr)	MEGD	T. 00			2. Date of De Month	Day	Year	3. Time of Death
	/Medic		MARY 4a. Facility Name (If not institution, gi	ive street and number)	NESB	LT	4b. City, Town, or	Location of Death	JANUAR		2007 ounty of Death	1910 M
<b>!</b>	Examin	ler	MEMORIAL				CUMBERLA				LLEGAN	
00 <u>. va</u>	Funeral		5. Social Security Number 6.		e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry)
	Director		230-30-1307	1□M 2∏F	80	Yrs.	World Buys	Trouis IVIII.	Mar 18			Virginia
	and ww		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Loc	ation					10d. Inside City Limits
	Maryl f sho led at	ō	MD Allegar	ny	C	Cumber]	Land					1 ☐ Yes 2√ No
	r 28a-	Director	10e. Street and Number	-			10f. Zip Code			10g. Citizer	n of What Cou	
	h with	a D	121 S. Allegany	Street				21502			****	
	deat ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	6. 13. W	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No	- 14.	Race - Ameri Black, White,	
2	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give	٧o		☐ Yes 2X No	Specify:		Sr		nite
Ś	hours tural"	d by	3	Year or Dates:		16a Decod	ent's Usual Occupa	ation			of Business/Ir	
2	in 72 "na" r	Completed	(Specify only highest g	rade completed)		(Give F	kind of work done of NOT use retired	durina most of work	ing	70D. Killa	or business/ii	ndustry unk
<u>v</u>	l with giene. r thai	E O	Elementary/Secondary (0-12)	College (1-4or 5	)+)	clerl	k					
2	at Hyg othe vent,	BeC	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	e (First, Middle,	Maiden Su	rname)	
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at	To	Chester William (	Dates				Angie M	ary Rav	enscro	oft	
0	2 sho and Is ma		19a. Informant's Name/Relationship				g Address (Street a					p Code)
≧ נוֹ	l and lealth im 27 ther to		Bonnie Roby/dau	ghter	20h Ble		Blue Jay		dgeley,			0:-
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec	cify)			sition (Name of natory or other plac				ion - City or T	
Dall	permit. Depart Import any inj		21. Signature   Funera ryice Lice	wade, Dir	ector		Name and Address ate Anato 1timore,			Balt	imore :	Street
ľ	*		23a. Part 1. Enter the disease, or co- shock, or heart failure. List on	mplications that caused y one cause on each li	the death.	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/	nati		1 -	Disea				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as			1					
	Lammer	Ļ	Sequentially list conditions,	b. Due to (or as		onno offi						
	ted nsit	Examiner	Sequentially list conditions, if the list is the list conditions, if the list is the list cause. Enter Underlying cause (Disease or injury that initiated events	Due to (or as	a conse qui	erice or,						
,	execu n and al-tra	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequ	ence of):					-	
5	icate be executed physician and s the burial-transit	dical		d								
9	rtificat ng phy as th	Medi	JE SELLIN S							I		
O. DO.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d	l. Date of deliv Month	ery Day Year
	that hed by detail	y Phy	Part II. Other significant conditions	contributing to death b	ut not resul	lting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use	contribute to t	the cause of death?
ה ה	quires n sigr ald be	d by							1 🗆	Yes 2 1	No 3∏Pro	bably 4 □Unknown
2	aw rei s bee 2 shou	ompleted							24a. Was		24b. Were aut	opsy findings available
	siclan: The law s certificate has b irector, page 2 s	mo						-	autoj perfo 1□ Yes	osy ormed? 2 ☑ No	death?	ompletion of cause of 2 □ No
2	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of Deat				20.10
>	hysic this ce al dire	To	1 Yes 2 No	Hospital: 1   Inpatie		R/Outpatient		4 Linuising no	ome 5 Resi	dence 6	Other (Speci	fy)
	After 1	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injury Work		28d. Describe	now injury o	ccurred	
200	ttend death stor:	icati	2 Accident investigati 3 Suicide 6 Could not	be 28e Place of ini	Inv - At hor	mo farm stro	M 1 ☐` et, factory, office	Yes 2 □ No	29f Logation (	Ctroot and A	Lumba v av Bur	al Paula Mumba
2	after all Direct din by	Certification:	4 ☐ Homicide determine	d building, et	c. (Specify)	)	et, factory, office		City or Tol	vn, State)	umber or <b>A</b> ur	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best aminer: On the basis o and manner st	f examinati	vledge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) an date and pla	d manner as a	stated. to the cause(s)
	To the Within To the Somple	Me	29b. Signature and title of certifier				29c. License	number		29d. Date s	igned (Month,	Day, Year)
,			1	-American			000	33280		JANUAF	RY 2C,	2007
			30. Name and address of person wh				Print)					
			Sunil Gupta	M.D. LZ	5 Ke	nt A	ve. Cu	mberla	nd, N	aryl	and	21502
	Sta Registr		31. Date filed (Month, Day, Year)	32. negisti	ars Signati		ask)			•		
	ogioti		FFB 0.5	2007 1	20 6	F GO	acts)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** O'Connor 30, 2007 Jeanne January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis

Vear | If Under 24 Hrs. Arbor Assisted Living Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex ear If Under **Funeral** Months Days 1 □ M 2 🕅 F Nov. 6, 066-18-6205 87 1919 New York **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical U.S.A. 7101 Bay Front Drive 21403 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Collins ပ္ Catherine Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis O'Connor Hammondsport, NY 14840 (Son) Box 23 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Johnson City, NY 4 Donation 5 Other (Specify) Calvary Cemetery 2/5/07 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility
J.A. McCormack & Son Funeral Home 141 Main St., Binghamton, NY lnun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Alzheimer's Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or trijury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1□ Yes 2 🛣 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No after death I Director: , d in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title dertifier 29c. License number 29d. Date signed (Month, Day, Year) D0029571 Febryary 1, 2007 of person who completed cause of death (Item 23a) (Type, Print) MD 2225 E Defense Hwy., Crofton, MD 21114 Resitrar's Signature 31. Date filed (Month. Year State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 9864 2-8-07 vt. State of Maryland 9 Department of Health and Mental Hygiene Amend #5 Per FH G865 3/14/07 Dertificate of Death 1 - State A 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 1, 2007 **Physician** MARY LUE OXNER 10:32A M /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | APR . 15 , 19 4 2 | MARYLAND 5. Social Security No 258 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F 6168 219 40 64 Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 ☐ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be n 1401 E. Oliver St. Apt.302 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 21213 USA an "natural", or items Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) 3 YEARS SUBSTITUTE TEACHER DEPT. EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ WASH LEE OXNER MARIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BALTO 19a. Informant's Name/Relationship (Type. Print) S Health a ESSIE HOLMES PEOPLES(godmother) 1400 E.MADISON ST. APT.1010 Department of Health Important: If Item 27 any Injury or other to once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Westiermer Disposition (Name of Place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TRINITY CEMETERY FEB.8,2007 BALTIMORE, MD. goature of Funeral Service Licenses 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner END STAGE RENAL DISEASE Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed Exami RESPIRATORY FAILURE Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) signed by the a Division or Vital Records, P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig CLOSTRIDIUM DIFFICLE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha rector, page 2 autopsy DISSEMINATED INTERVASCULAR COAGULATION 1□ Yes 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D31826 11CUL 2-1-07 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

RICHARD

31. Date filed (Month, Day, Year)

LINTHICUM

2007

05

M. D.

32. Registrar's Signature

7601 OSLER DRIVE

TOWSON,

MARYLAND 21204

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Herbert Francis O'Donnell 26, 2007 January 9:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Evergreen Assisted Living Baltimore City If Unde 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Min 1**X**☐M 2☐F Months Yrs. Director 471-05-6427 Sept. 15,1915 Minnesota Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3009 Evergreen Ave. 21214 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu vent, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Years Engineer Western Electric 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Charles O'Donnell Anna Marie Gohoe ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 7233 Gough Street Baltimore, Maryland Mr. Keith O'Donnell (Son) 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o Hilltop Service Corp. 2/3/2007 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland dure of Funeral Service Licensed 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) WG Mi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed and -physician a s the burial-1 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown has been si Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate ha 1∐ Yes

Be ပ Certification: within 24 hours after death

To the Funeral Director:
Completely filled in by the

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25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🗆 Nursing Home 1 Yes 2 No 5 ☐ Residence 6 XOther (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of

1 Natural 2 Accident 5 Pending Injury investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29a. Certifier

29c. License number D41901 29d. Date signed (Month, Day, Year) Z \_ \ \_ 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rowien, MD 515071 31. Date filed (Month, Day, Year)

State Registrar

Medical

FEB 05 2007



2

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ROBERT 2359 FEBRUARY I, PARRISH 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HORTINS BAYVIEW MEDICAL CENTER BALTIMORE N/A 8. Date of Birth (Month, Day, Year)
JAN. 28,1939 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1**X** M 2□ F 218-44-1516 68 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or itema 23a or 28a-f ahow the Medical Exercises must be notified at 1 X Yes 2 No Director N/ABALTIMORE 10e. Street and Number 10g. Citizen of What Country? 810 S. DEAN STREET 21224 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 FORKLIFT OPERATOR permit. Peges 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other th any hijury or other traumatic avent, Lta Onca. MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT LEE PARRISH CATHERINE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA PARRISH/ WIFE 810 S. DEAN STREET, BALTIMORE, MD. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 2/5/07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & CEILER INC. FUNERAL HOME 700 S. CONKLING ST., BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARGE ISCHEMIC STROKE /Medical Due to (or as a consequence of) Examiner ATRIAL FIBRIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. MELLITUS 1XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No HYPERTENSION 1 ☐ Yes 2 ☑ No within 24 hours efter death. To tha Funaral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) cai Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 MS 4940 EASTERN AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ANIL SURYAPRASAD
31. Date filed (Month, Day, Year) BAYNTEW BALTIMORE MARYLAND 21224 JOHNS HOPKINS 32. Registrar's Signature State FEB 0 5 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens		Ē	el Air 3 Ne	wport Driv	e Forest Hi	apel& Cremat: 11, MD 21050	ion Services			
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Вох	leath certific attending plifor use as 1	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2	Fetal death 3	□Ectopic pregnancy	/		23d. Date of de Month	livery Day Year			
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	(Check only 2 Medical Exami	Residen: To the best of ner: On the basis of e	my knowledge, dea xamination and/or i	ath occurred at the tir	ne, date and plac	e, and due to the ca	ause(s) and manner as	s stated.			
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•	(8)		30. Name and address of person who co	moleted cause of don	th (Item 23a) /Tun-	Print)	1464						
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PEENELC, HENRY FELTら Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, 6

	State of Maryland / Dep			ble.
	1- State Registra Amend #5, perFh, g880 6/19/08 Tee		Reg. No. 20	07 03 36
Physician /Medical	1. Decedent's Name (First, Middle, Last) HENRY Felton Perve	1/	2. Date of Death Month Day JAN 27	Year 3 20 A M
Examiner	4a. Facility Name (If not institution, give street and number)  CIANAL HDSPITEZ OF BATTIMERE	4b. City, Town, or Location of Death  BAUT WONE	4c. County	of Death
Funeral Director	5-Factor Security Number 6. Sex 10 M 20 F 7. Age (In yrs. last birthday, Yrs.		8. Date of Birth (Month, Day, Year) APT / 21, 1935	9. Birthplace (State or Foreign Country)  Dillow, 5. C.
a-f show tiffed at	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  10b. County 10c. City, Town or L	ocation		10d. Inside City Limits 10d Yes 2 □ No
23a or 28a-f slust be notified	10e. Street and Number 2923 Ulmon AVE	10f. Zip Code 212-15	10g. Citizen of V	What Country?
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permit, rages I Department of H Important: If ite any Injury or ot	4 Donation 5 Other (Specify)	end Ceme tery Feb	5, 2007 Laffa	City or Town, State
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ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the the Dabules Mellium, Respuration	A A		ribute to the cause of death?  3 □ Probably 4 ☑ Unknown
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s certific lirector,	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 Inpatient 2 ☐ ER/Outpatie	Other	(Check only one)	
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us after death. In after death. Ited in by the funer.  Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)		28f. Location (Street and Numb City or Town, State)	·
ithin 24 hours the Fune on the Fune on the Fune ompletely fill Medical	29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, deal (Check only one)  Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause(s) and ma red at the time, date and place,	anner as stated. and due to the cause(s)
To the comp	29b. Signature and title of certifier  August Nauvaatur No	29c. License number		(Month, Day, Year)
5	30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	amore	,
State Registrar	RANDAM RAMMANAM ) SINA1 H 31. Date filed (Month, Day, Year)  FEB 0 5 2007  S2. Registrar's Signature		1/ EACONCE	

O7-00805  Timothy Robinson  Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene								
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Physicia	ın/	Decedent's Name (First, Middle, Last)	2. Date of Death	1	3. Time of Oeath			
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		Laurel Regional Hospital Laurel	2(1)	Prince George				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24H		h(MM/DD/YYYY) 9. Bir				
Director		3/1-/0-0/40 1 XM 2 F 4/ Yrs.	in Oct.16		untry) Md.			
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	···	<u> </u>	10d. Inside City Limits			
and show	٦,	Md. N/A Baltimore			1 Yes 2 No			
Maryl: r 28a-f	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Coul	ntry?			
ith the		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Sanati Van as Na	451	1			
eath w	Funeral	1 Never Married 2 Married 2 Married 2 No If Yes, specify Cuban, Mexican, Puel	to Rican, etc.)	White, etc.	can Indian, Black,			
after o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	acK			
2 hours		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r		16b. Kind of Business/l	ndustry			
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S 8 1- E		Mrs. Sandra Horn 14858 Birwood	St. Det	troit Mic	119an 48238			
more, MC Pages   and 2 s nent of Heath ar ant: If item 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town State			
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Baltii permit Departm Importa	Į	21 Signature of Funeral Service Licensee 22 Name and Address of Facility Seeph L. Russ F	uneral t	tome, P. A.	- 1/			
Physician		23a. Pet I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac faulure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and			
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Division tal or Attendir trs after death. al Director: A	icati	2 Accident Investigation 28e Place of Injury . At home, form street factory office building etc.	28f Location (St	troot and Number of Du	sel Doube Number City			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a cone)		, .				
Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed)								
	=	Some of Resetting of Man.		January 30, 2007				
		30. Name and address of person who completed cause of death (Item 23a)						
V		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201	<del> </del>	-			
	State 31. Date filed (Month, Day, Year)  Registrar FEB 0 5 2007							

			For State Registrar	State of M	arylan	•	artmen rtificat			nd Me	-	ene 0	07	03138
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	Funeral Director		212-26-2199	ax 7. Ag □M 2⁄∏ F	78 (In yrs. I	ast birthday) Yrs.	If Under Months		If Under 24 Hours	Min.	B. Date of Birth (Month, Day, aug. 8,	Year) 1928	9. Birthp Coun	lace (State or Foreign try) MD
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	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origin n, Mexican, F	n? (Spec Puerto Ri	ify Yes or No- ican, etc.)		ce - Americ ck, White,	
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	Vithiu To the	Σ	29b. Signature and title of certifier			/	290	c. Licensi	number	0	29	d. Date signe	ed (Month,	Day, Year)
	3		Karra	zenaga	4	MO		リら	428	X		esm	ary.	3 2007
	6		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)	NR	White	ext 1	tyspita	al Ce	de	
	Sta Regist		31. Date filed (Month, Day, Year)	007 32 Regist	rar's Signa	ture	and I							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Thandall 31,0007 curice anvary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore owsen If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07.11.1948 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) Months Days Hours Min. 217-54-4738 Usual Residence of Decedent 1 M 2 X F Yrs. Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No haltimore MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3403 Woodbine 1.3.A I. Race - American Indian, Avenue 21207 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 📉 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years oppin Star College 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ames M. Bennett Eaton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Burgess 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Replace of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) n Foxest O2.010.2007 Owner Mills, MD 22. Name and Address of Facility Vaugran C. Greene Puneal Service 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberry Road "Randall Stain MD 21133 Approximate Interval Between Onset and Death a. METASTIC GUARIAN CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE 1 Yes 2 No Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury

1 ☐ Yes 2 ☐ No

LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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29d. Date signed (Month, Day, Year) 2/1/07

Physician /Medical Examiner

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Records, P.O. Box 68760,

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Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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State

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

32. Regi

2800 Dulaney

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 2007 Richard G. Smith M 90110 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital DALTIMORE or 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Days Months 1X M 2 □ F Hours Mary Land 87 Yrs. **Director** June 10, 1919 216-03-0043 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any fully or other traumatic event, the Medical Examiner must be prostated. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2K No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR 635 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 22 Married 1 ☐ Yes 2 ☑ No þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard G. Smith, Sr. Elizabeth Born 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty W. Smith / Wife 719 Maiden Choice Ln., HR 635, Catonsville, MD21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory Feb. 2,2007 Catonsville, MD 4 ☐ Donation 5 ☐ ther (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, MD 21228 21. Signature of Funeral Septice Licens **№**01290 23a. Part1. Enter the visuase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASPIRATION PHEUMONIA MONTH /Medical resulting in death) Due to (or as a consequence of) Examiner LYMPHOME 6 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. attending physician a for use as the burial-Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No autopsy perform 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P20656 FEB1,2007

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

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Division or

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State Registrar 31. Date filed (Month, Day, Year)

KONSTANTIN ZUBELEVITSKLY 900 S. CATON AVE, BALTIMORE, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regiatrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30A 5 200 Howard Shown /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner SCAALE

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Baltimor SAULTE 60ex 10XM 20F 20 1030 ANKLIN Social Security Number Year 7. Age (In yrs. (ast birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Director 239-24-5595 83 6/27/1923 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow other treumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Inent of Heelth and Mental Hygiene. Int: If Item 27 ie marked other then "natural", or Iteme 23a or? 607 Lanoitan Road Apt B 21220 Completed by Funeral S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 XTNo If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jehu B. Shown Emma Duree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 permit. Pages 1 and 2 of Department of Heelth ar important: if item 27 ie any injury or other treugnore. 607 Lanoitan Road Apt. B Margaret Shown (Wife) Middle River, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 2654 2664 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Cemetery Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 lichar 90ffr 50-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 215 /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physicien and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records. P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has this certificete 2 No 1 ☐ Yes ieral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 [7] Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours a To the Funeral I 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the e 29b. Signature and title of certifier 29c. License number 000000560 cause of death (Item 23a) (Type, Print) RIVER NECK PL # 109, BALTIMORE, MD PANKAJ KITE WOLFAN 201, BACK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 05

2007

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f perME, G864,02/01/07dhb

Red, No. 1. Decedent's Name (First, Middle, Last) **Physician** Month JANUARY, 23, 2007 Maria Camilleri Simmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SINAL HOSPITAL OF BALTIMON Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 214-36-9100 **Director** 15 1939 Italy Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County artment of Health and Mental Hygiene.

ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show
Injury or other traumatic event, the Medical Examiner must be notified at Carrol1 1 ☐ Yes 2 No IKESVILLE MD Funeral Director 10e. Street and Number 10g. Citizen of What Country? USA WENDY ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Completed by 3 ♥ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) bookkeeper clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvatore Camilleri Concetta Fertittia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Marie Simmons (daughter) 5332 Wendy Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 1-27-07 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Paige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRAL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): YPER TENSION Examiner Sequentially list conditions, it any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last INTRAVEN TRICULAR Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month 4☐Pregnant at time of death 9□ Unknown 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed' 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes - 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Subject fell 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 2 Vatural 2 2 Accident PERTENSION 18 2007 Unknown 1 ☐ Yes 2 No Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, MD 4 Homicide 5332 Wendy Road, Sykesville, To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) JANUARY, 23, 2007

Registrar
DHMH 17 Rev 1/2001

State

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BELEVEDER AVE

BALTIMORE MD 21215

2401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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SYLVANUS

31. Date filed (Month, Day, Year)

JAN 25

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name (First, Middle, La	st)					Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Melvin T. S	hillenn					bruary	1, 2007	4:16A M
5	Examin	. 2	4a. Facility Name (If not institution, given			4b. City, Towr	, or Location of	f Death		4c. County of Deat	h
			Gilchrist Center	for Hospi	ce Care	Towson	n			Baltimo	re
	Funeral Director		5. Social Security Number 6. S 216-16-2454		e (In yrs. last bii 83			Min.	Date of Birth (Month, Day, You 11y 7,19	ear) Co	hplace (State or Foreign untry) MD
	and W	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
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	he M	Director	MD Balti	more		Reistersto			10=	. Citizen of What Co	
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	s 23	ral	2 Cherry Hill C		From in 11 C	40 Mas Doordont s	21136	-in2 (Cnacify	Vec or No	US.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:		13. Was Decedent of if Yes, specify C		i, Puerto Rica	an, etc.)	Black, White	
Ö	2 hou	Completed	15. Decedent's E	ducation	16a	Decedent's Usual Oc	cupation	t of working	16	b. Kind of Business/	Industry
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פ	e file al Hy othe vent,	Be	17. Father's Name (First, Middle, Las	")			18. Mother	r's Name (Fi	rst, Middle, Ma	iden Surname)	
<u>la</u>	uld b Venta rrked	To E	Leo T. Shillenn				L	Lillian	n Phill	ips	
ary	sho and is	•	19a. Informant's Name/Relationship	(Type. Print)	191	o. Mailing Address (Stre	eet and Numbe	er or Rural Ro	oute Number, C	City or Town, State, 2	Zip Code)
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re	of He item		20a. Method of Disposition	75 11 01 1	20b. Place o	of Disposition (Name of ery, crematory or other	olace)	Date	20	c. Location - City or	Town, State
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alti	mit.		21. Signature of Funeral Service Lice	nsee	1/-	22. Name and Ad				Reisters	
Ö	Del Del		Stephen	- M. H	enten	Eline Fu	neral H	Home,	Reist	erstown,	MD 21136
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		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as	a consequence	of):					
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P.O. Box	The law requires that the death cert tte has been signed by the attending bage 2 should be detached for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of del Month	livery Day Year
	that ned b	Y P	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlying cause	given in Part I.		23e. Did toba	cco use contribute to	the cause of death?
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Division or Vital Records,	w rec	Completed							24a. Was an	24b. Were au	utopsv findings available
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and little of certifier	0		29c. Lic	ense number		29d	I. Date signed (Mont	th, Day, Year)
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	11		30. Name and address of person who	completed cause of o	leath (Item 23a)	(Type, Print)					
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	Sta	it <u>e</u>	31. Date filed (Month, Day, Year)	3 Registr	ar's Signature	Angelis.					
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 31 2007 **Physician** 1:50 P DOROTHY **SHELLER** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 SLADE AVENUE APT. #110 BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕶 F Yrs. 216-07-1884 04/05/1920 Director 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M-dical Examiner must be notified at 1 ☐Yes 2 X No BALTIMORE MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 7 SLADE AVENUE #110 21208 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event 17. 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State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 29d. Date signed (Month, Day, Year)

2700 QUART LAKE DR STE220 BALTEMONE MD 21209

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Rosalind 4:00P January 26 2007 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3160 Gracefield Road #1527 Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 1, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 21 ☐ F New York 88 1918 Director 095-14-0787 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
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Department o
Important: If any Injury or \* 4 X Donation 5 ☐ Other (Specify) 21. Signatur of Funer Service Licensee ROyald S. Ware 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director my 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Clostridum difficile Priysician /Medical Due to (or as a consequence of): **Examiner** Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Renal the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed alure Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. detached ۾ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 212 No 1 ☐ Yes 2 ☑ No 1 Tyes : After this certification funeral director. To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Injury 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Loveen D59524 January 26 2007 himang 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEENJ. PUTHUMANA, 3110 GRACEFIELD ROAD SILVER SPRING, MD 20904 31. Date filed (Month, Day, Year)

State Registrar

FFR 0 5 200



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) January 31, 2007 **Physician** Howard Travers, 5:00 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 83 Shawqo Court Middle River If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours ty☑M 2□F 11/07/1952 Maryland 54 Director 213-60-4905 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 7.1s marked other then "naturel", or items 23e or 28e-f show treumatic event, it is Marical Examinar must be mailfied at Maryland Baltimore Middle River 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21220 83 Shawgo Court U.S.A. Funeral 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other then "naturel", or ite 1972 Notif Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€XNo Specify: à 1974 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Steel Worker Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Travers, Sr. Margaret Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Travers (Wife) 83 Shawgo Court, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 permit. Page Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02/05/2007 Baltimore, Maryland 21. Signature of Funeral Sentes Licenses 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 2122 23a. Part1. Enil r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat / Cause (Final disease or condition resulting in death) ATHERUSCLEROTIC GARDIONASCUAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Tunknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed After this certificate 1 Yes 2 🗆 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation nerel Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide the Funerel 1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 FEBRUARY 1, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAETER ML, MD Rs. \$109 201, BACK RIVER BALTIMORE, MD gistrar's Signature Day, Year) 31. Date filed (Month, State 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

10

DIVISION OF CARDIOLOGY, WIN OF MD 22 SOUTH GREENE STREET

BALTMORE MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AM

FEB 05

MARK VESELY,

31. Date filed (Month, Day, Year)

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death							
E C	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 7/30 PM  Christine Wise 4b. City, Town, or Location of Death 4c. County of Death							
	Funeral Director		Frank in Squark Hospital Residence of Decedent    Social Seculity Number   Sex   1 - Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Sex   Months   Days   Hours   Min.   (Month, Day, Year)   Sex   Sex   1 - M 27   F   62   Yrs.   Months   Days   Hours   Min.   (Month, Day, Year)   8/6/1944   Maryland							
	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or items 23e or 28e-f ehow that the Medical Examiner must be notified at	Funeral Director	0a. State     10b. County     10c. City, Town or Location     10d. Inside City Limits       Maryland     Baltimore     Essex       0e. Street and Number     10f. Zip Code     10g. Citizen of What Country?							
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examiner must be notified at ODEs.	5	1418 Galena Road  1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  1. Was Decedent Ever in U.S. Amed Forces? 1 Yes, Give Year or Dates:  1. Was Decedent Ever in U.S. Amed Forces? 1. Yes 2 Mo Specify: 1. Yes 2 Mo Specify:  1. Yes 2 Mo Specify: White							
Maryland 21215-0036	filed within 72 h Hygiene. Other then "netuent, the Medica	e Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+) 2  College (1-4or 5+) 2  Administrative Assistant  16b. Kind of 8usiness/Industry  16b. Kind of 8usiness/Industry  Education  Education  17. Father's Name (First, Middle, Last)							
Marylan	nd 2 should be lith and Mental 27 is marked ( r traumatic eve	To Be	Adam Frank Cudnik  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Baltimore,	mit. Pages 1 a periment of Hec cortent: If Item / Injury or othe		20a. Method of Disposition  1							
	eded in the state of the state		Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221  23a. Part1. Enter the disease or coordinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death  Approximate Interval Between Onset and Death  Onset and Death							
9760,	/Medical Examiner  hysician and  the prijal-transit	resulting in death)  Due to (or as a consequence of):								
P.O. Box 687	death certific e attending p ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1  Sectopic pregnancy 23d. Date of delivery 23d. Date of delivery 4  Month Day Year							
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of Vital R	Physicien: The rthis certificate harmal director, page	To Be	performed?   death?   1   Yes 2   No   No   Yes 2   No   No   Yes 2   No   No   No   Yes 2   No   No   No   No   No   No   No							
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	To the Hoepital within 24 hours and the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)							
}	6		Vogesher Res 00000 February 1, 2007  30. Name and address of person who completed cause of death (Item 23a) (Type, Point)  The Vogesh News 1650 1000 Frank Lin Scarab Traile Rollings Mr. 21232							
	Sta Regist		31. Date filed (Month, Day, Year)  FEB 0 5 2007  32. Relaistrar's Signature							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Joseph Clinton White 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Squale Hospital Balti ROSE dale der 1 Year | If Under 24 Hrs more ranklin 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Days Hours Months 1X M 2 ☐ F 77 217 24 4867 June 17,1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1002 Cedar Creek Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clinton Joseph White Hazel Steinke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret White (Wife) 1002 Cedar Creek Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐xBurial 2 ☐ Cremation 3 ☐Removal from State Holly Hill Mem. Gardens 2/7/2007 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760 signed by the a this certificate funeral ours after death.
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Physician/Medical

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**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

State Registrar

DHMH 17 Rev 1/2001

EPHB, KLIGARDAN 31. Date filed (Month, Day, Year)

29b. Signature and title of certiffer

(Check only one)

NO 416 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

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29d. Date signed (Month, Day, Year)

**ORIGINAL** 

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	Funeral Director		5. Social Security Number 574–14–9764	6. Sex 1 ☐ M	2 <b>X</b> F		last birthday) 62 Yrs.	Months	Days	Hours	Min. O	B. Date of Birth 1702/17	945	9. Birth	place (State or Foreign untry) PA
			Usual Residence of Decedent												
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land	ild be fited ental Hygi ked other ic avant, I	To Be	17. Father's Name (First, Middle, Clarence Gor		inshi	p						Mae Ba		ame)	
Maryland 21215-0036	id 2 should lith and Men 27 Is marke traumatic	-	19a. Informant's Name/Relations Patricia Emert	hip (Type,	Print) USIN		19b Mailir 2384	ng Address 4 Gla	(Street a	nd Numbe Pike,	or or Rural i	Route Number erset,	PA 155	obState, Z	ip Code)
Baltimore,	Pages 1 and nent of Health int: If itam 27 iry or other ti		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 4 □ Donation 5 □ Other (5	3 □Rem	oval from S	1010	Place of Dispondent Commetery, crer	natory or o	ther plac	9)	Da 02/03	/2007	20c. Location Balti		
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Вох	death certifica e attending ph d for use as th	an/N	1F FEMALE: 23b. Was decedent pregnant	23c.		ome of pregn		Ectopic pr	egnancy					Date of deliv	
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	ne Hos 124 h na Fur	edical	(Check only 2 Medical one)	Examiner	On the ba	sis of examina er stated.	ation and/or in	vestigation	, in my op	oinion, deat	th occurred	f at the time, d	ate and place	e, and due	stated. to the cause(s)
	To the Hosp within 24 ho To the Fund completely f	M	29b. Signature and title of certifie					290	. License	number		2	9d. Date sign	ned (Month	Day, Year)
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	1		30. Name and address of person	who comp	leted cause	of death (Ite	m 23a) (Type. KENWO	Print)		Towso.		40 21	204		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 9;42 A M **Physician** Ward Jan 2007 Beatrice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia Hospital General Howard Canty H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. July 31, 19 Birthplace (State or Foreign Country) 5. Social Security Number 0 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗑 F Yrs. 1930 76 Washington DC 577-44-3770 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan satment of Heelih and Mental Hygiene. sortant: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow injury or other traumatic event, the Medical Exporter must be published at 1 ☐ Yes 2√ No Ellicott City Howard Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21042 USA 4236 Buckskin Lake Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced \$ 16b. Kind of Business/Industry unk Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis A. Biberstein Helena Keane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4236 Buckskin Lake Drive Ellicott City, MD 21042 Paul Kendall/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
State Anatomy Baord 655 W. Baltimore Street
Baltimore, MD 21201 21. Singulare of Euneral Service Licensee Director 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Ith Immediate Cause (Final disease or condition resulting in death) Physician (cerebra) Vescolon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and the for use as the burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical Medical Certification: To

Hospital or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Funeral Director; After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact within 24 hours a To the Funeral I

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with the Maryland

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year	
	ntributing to death but not resulting in the undertying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Frobably 4 Unknown
Days venous The	com 605: 5 Hyperten son	24a. Was an autopsy performed?  1 Yes 2 100 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 100
2 . Was case referred to medical	26. Place of Death (C	Check only one)
avaminer?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Location (Street and Number or Rural Route Number, City or Town, State)
29a. Centifier Centifying The (Check only 2 Medical Exam	relicians To the best of my knowledge, death occurred at the time, data and place, and inter: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

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Jan 27,200)

State Registrar 31. Date filed (Month, Day, Year) FEB 0 5 2007

Deleon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 30 2007 13:50PM" JAN. CARL ALBERT BAER /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FROSTBURG VILLAGE NURSING HOME FROSTBURG ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1♥M 2□F 79 Yrs. PA Director 193-24-6419 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No FROSTBURG MD ALLEGANY Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21532 UNITED STATES 16706 OLD NATIONAL PIKE SW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married WHITE 1 Yes 2 No Maryland 21215-0036 Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) CONSTRUCTION Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. LABORER permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If item 27 is marked other It any Injury or other traumatic event, ITA Once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JACOB BAER SARAH BAKER BAER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LEOLIA R. BAER, WIFE 16706 OLD NATIONAL PIKE SW, FROSTBURG, MD 21532 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State REST LAWN MEMORIAL GARDENS2-1-07 CUMBERLAND, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signatury of Funeral Service Licensee 60 W. MAIN STREET MO0547 SOWERS FUNERAL HOME, P.A. Dwess 100 FROSTBURG, MD 21532 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis **Physician** Syndrome 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Dementa advanced 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 220 No 24a. Was an 2 No Division of Vital 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: Al 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) Fo the h 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number D0055325 Jan 31, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostbing MD MD 21532 Tavan 48 Terrace SHIN WONSOCK 31. Date filed (Month, Day, Year) 32 egistrar's Signature State Registrar FEB 0 5 2007

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State of Marylan		artment of H			ene 60	7 03153
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Ada Edelen Burns					2. Date of Death Month	Day Ye	ar 10:10 AM
Examine Funeral Director	er	4a. Facility Name (If not institution, give s 402 McDowell Avenue 5. Social Security Number 220-64-6115	e, Apt. 2B	last birthday) Yrs.	4b. City, Town, or  Hagerst  If Under 1 Year  Months Days	own	8. Date of Birth (Month, Day, Y	4c. County of E Washi:	Death  ngton  Birthplace (State or Foreign  Country)
g	_	220-04-0115	10c. Cit	y, Town or Lo			02/05/19	49	10d. Inside City Limits
with the Mi a or 28e-f	Funeral Director	10e. Street and Number 402 McDowell Avenue		agerse	10f. Zip Code 21740	)	100	g. Citizen of Wha	t Country?
033	þ		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of Hist f Yes, specify Cubar 1 ☐ Yes 2√2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc. Black
21215-0036 ad within 72 hours af giene er then "natural", or t, the Medical Exami	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Cottege (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired) Iomemaker	tion uring most of work	sing	Sb. Kind of Busine	
Baltimore, Maryland 212: sermit. Pages 1 and 2 should be filed within beardment of Health and Mental Hygiene. mportant: If Item 27 is marked other then my injury or other treumatic event, tra Ma	To Be C	17. Father's Name (First, Middle, Last) Norman Dent Butler					e (First, Middle, Ma (unk) Ly		
and 2 sho ealth and m 27 is m		19a. Informant's Name/Relationship (Type Anna L. Gross / Si	ster	1475	Grays Ro	ad, Port	Republic	-	1
Baltimore, Misperial Pages 1 and 2 Department of Health important: If Item 27 is eny injury or other treasons.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	emetery, cren	sition (Name of natory or other place  L Cemetery	9)		oc. Location - City Hagersto	
Balt permit. Departi import eny inj once.		21. Signature of Funeral Service License			Name and Addres O5 N. Pot	s of Facility Ge	rald N. M	Minnich	Funeral Home
876( ate be hysicie the but	dicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conseq	uence of):	er the mode of dying		CL	,	Approximate Interval Between Onset and Death
O. Box 6 the death certif y the ettending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	Sc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	þ	Part II. Dther significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did toba 1 ☐ Yes	\ \	te to the cause of death?  Probably 4 Unknown
Vital Reco	Completed						24a. Was an autopsy performe	prior	
hys this	Certification: To Be	25. Was case referred to medical examiner?  1	ospital: 1 Inpatient 2 I 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing H	th (Check only one) ome 5 Resident 28d. Describe how	ce 6 Other (	Specify)
5 6 9		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			City or Town,	State)	r Rural Route Number,
To the Hospitel of within 24 hours a To the Funerel Completely filled in	Medical	one) 2   Medical Examin	ician: To the best of my kneer: On the basis of examina and manner stated.	tion and/or in	vestigation, in my op	inion, death occur	red at the time, date	e and place, and	due to the cause(s)
To To D	-	29b. Signature and title of certifier	and l	ou	29c. License	4647	2	I. Date signed (M	00 - 1
Star Registra	-	30. Name and address of person who could be seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen a seen and address of person who could be seen as a seen a se	32. Registrar's Signa	· OM	1130	OBEL	cT.	Hager	CIM nwork

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Amy C. Brittingham 01 2007 1539 P 17 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicomico Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 1 F Months Days Hours Min. 86 19 212-14-4516 1920 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 N. Main St. 21811 USA 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No U.S. 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Army 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S.Postal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther David Calloway Pauline Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest O. Brittingham 323 N. Main St., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Evergreen Cemetery 1/21/2007 | Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Lung Cancer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No 25. Was case referred to medical OF Diseas of Death Ch.

Physician /Medical Examiner

**Physician** 

/Medical

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Director

Funeral

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**Funeral** 

Director

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72 hours after

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and 2 should be fill tealth and Mental H m 27 is merked ott

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other trau

Saltimore, Maryland 21215-0036

Box 68760

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To the Hospital of within 24 hours af To the Funeral D

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the burial-tran attending physician as for signed by the a page 2 certificate has this After 1

Exami Physician/Medical þ Completed Be 2 funeral ( e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the telety filled in by the funeral Certification:

Medical

State

Registrar

examiner?		20. Trace of Beauti Check Offi Offe										
1 ☐ Yes 2☐	No	Hospital: 1 XInpatient	2 ER/Outpatient	3 🗆 🗅	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Deat  1 X Natural  2 □ Accident	5 ☐ Pending investigatio		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		- At home, farm, stree Specify)	et, facto	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier	1 Certifying Pl	nysician: To the best of n	ny knowledge, death o	occurre	d at the time, date and place	ce, and due to the cause(s) and manner as stated.						

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D26278

1-22-2007

David E. Cowall, M.D.

31. Date filed (Month, Day, Year

JAN 2 3 2007

Coastal Hospice P.O. Box 1733, Salisbury, Md. 21802

BA 10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State #Registrar 7, #8, per F. Home, 1/30/07, B. Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** John Marlin Brown 20 2015 Jan. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth:  $\frac{3}{4}$   $\frac{1}{4}$   $\frac{4}{3}$   $\frac{4}{9}$  . Birthplace (State or Foreign (Month, Day, Fear) 4  $\frac{1}{4}$   $\frac{1}{$ 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1[XM 2□ F 214-32-1927 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or iteme 23s or 28s-f eho the Medical Examinar must be notified at 1 ☐ Yes 2√√No Director MD Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8511 Nine Pin Branch Rd. 21811 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Heavy Equipment Operator and Mental Hygier is marked other if Construction permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy importent: if item 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Henry Brown Florence Wainwright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Brown (wife) 10325 Bristol Rd., Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. Jan.25,2007 Frankford, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee Porta 108 William St., Berlin, Md. 21811 73a. Part1. Enter the disease, or per ations that callsed the lear shock, or heer failure. List only one cause on each line. fenter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CVA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ARREST 1 Yes 2 No 3 Probably 4 Unknown TIDENDARTERECTOMO 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform

The law requires thet the death certificate be executed this certificete Vital or Attending Physicien: within 24 hours effer deeth. To the Funerel Director: Affer this certific completely filled in by the funeral director, Division of -192 Š John

Completed by Be 2 Certification: Medical

1 Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 □ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of

27. Mapner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1) Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the date of and manner at stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cort ier 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PROAD 31. Date filed (Month, Day, Year)

29a. Certifier

JAN 2 3 2007

BERLIN MD 201 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician ROBERT DAVID CUNNINGHAM 200 /Medical 4c. County of Death WASHINGTON Facility Name (*If not institution, give street and number*) WASHINGTON COUNTY HOSPITAL 4b. City. Toy Examiner n, or Location of Death HAGERSTOWN . Age (In yrs. last birthday, 9. Birthplace (State or Foreign Social Security Number 217-05-1180 If Under 1 Year | If Under 24 Hrs 8. Date of Birth SEAPTH, Day (Year) 1918 **Funeral** Days Months Min 1 □**X**M 2 □ F Hours Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits MARYLAND WASHINGTON **HAGERSTOWN** 1 ☐ Yes 2 No Funeral Director Street and Number 19800 TRANQUILITY CIRCLE 10f. Zip Code 10g, Citizen of What Country? 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1-4or 5+) TRUCK MANU. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES WILLIAM CUNNINGHAM GLADYS IRENE SMITH ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12525 ASHTON ROAD, CLEAR SPRING, MARYLAND ROBERTA J. YETTER, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 □Removal from State GREENLAWN CEMETERY 1/26/2007 WILLIAMSPORT, MARYLAND 4 Denation 5 Other (Specify) 22. Name and Address of Facility 21. Sign ture of 7606 OLD NATIONAL PIKE PAUL M. DEAN BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) enal **Physician** 2 weeks /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine -- cli Hospital or Attending Physiclan: The law requires that the death certificate be executed 2 weeks burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760 nding physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 □ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy perform 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 P. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of Parson who completed cause (fideath (Item 23a) (Type, Print)

32. Registrar's Signature

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Division or Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year) JAN 22 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Truong Bao, M.D. 9715 Medical Center Drive, #201 Rockville, Maryland 20850 egistrar's Signature

29c. License number

00057124

29d. Date signed (Month, Day, Year)

			1- For Amend Item 8 Stata Registrer WCHD/SH 1/	State of Ma		-	artment <i>tificate</i>					giene		03158
	Dhunini		Decedent's Name (First, Middle, Last		-1 111					1	2. Date of De			3. Time of Death
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	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				July 3	0, 1	911	10d. Inside City Limits
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و	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If them 27 is marked other than "natural; or iteme 23a or 28a-f show any njury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2 11 If Yes, Give Year or Dates:			Vas Decede IYes, speci I□Yes 2		spanic Ori n, Mexicar Specify:	igin? (Spec n, Puerto R	ify Yes or No ican, etc.)	)-	14. Race - Am Black, Whi	te, etc.
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, ע	of He of He if item		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name natory or oth	e of her place	9)	Da	te	20c. Lo	cation - City or	Town, State
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2	tal or Atters as after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At hom c. (Specify)	ne, farm, stre	eet, factory,	office		28	If. Location (S City or Tox	Street and vn, State)	d Nu <b>m</b> ber or Ri	ural Route Number,
	To the Hospital of Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  The Funerial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best on hiner: On the basis of and manner sta	f examination	ledge, death on and/or inv	occurred at estigation, i	t the time	e, date and inton, deat	d place, an th occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
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4	- ]		30. Name and address of person who co	completed cause of d		23a) (Type, i		_ s-	~ h	ALE	252	ow.	~ ~	0 21748
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Ave., P.O. Box 2665, Laplata MD 201646

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Jenkins

31. Date filed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** UA N /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year washington Washington (a If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1X M 2□ F Director 217-12-1652 85 30, 1921 Maryland Sept Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Director Washington Maryland Hagerstown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 215 N. Locust St. 21740 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗖 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner Tax Service 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be ၀ Clarence Roy Disert Elizabeth Jeanette (McLaughlin) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie J. Disert / Wife N. Locust St. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/30/2007 Rest Haven Cemetery Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave Hagerstown Maryland 21742 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a cons) quence of): disease or condition resulting in death) Va Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 KER/Outpatient 3 DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner be executed

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Baltimore, Maryland 21215-0036

Box 68760,

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permit. Pages Department of Important: If It any injury or o

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State Registrar 4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

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29d. Date signed (Month, Day, Year)

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Geraldine Elizabeth Durbin January 21, 2007 12:30PM<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Care Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ■ M 2 X F Months Days Hours Director 220-26-5086 March 16 1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Madical Examination sust by multiple at 1 ☐ Yes 2 No Director Maryland Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20726 Trovinger Mill Road 21742 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify. Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. 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Describe how injury occurred After Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1.21,0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTOWN MD MANU ASHA JAN 2 32. Begistrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 19, 2007 **Physician** GOLDWIN DYKE 05:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN NURSING AND REAHBILTATION CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 ☐ F Hours 711-09-9017 95 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at KENT CHESTERTOWN 1 ☐ Yes 2 No Director 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 415 MORGNEC ROAD 21620 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry markad other then Elementary/Secondary (0-12) College (1-4or 5+) AIR TRAFFIC CONTROLER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental H is marked ot Be ROBERT EDWARD DYKE AMELIA JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. ROBERT DYKE/SON 1340 10TH MANOR, VERO BEACH, FL 32960 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATORY 01/20/2007 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, PA 130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Artovo Schovotic Cardio Vascular Disense **Physician** disease or condition resulting in death) 12 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HTN: Volvalus a Colon Rosection 1998 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed BPH & Obstruction; Arthritis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan has 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 4000 50996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Chartertown MD 21620 Neil Stoddord MD 31. Date filed (Month, Day, Year) 32. Regis ar's Signature Registrar

			For State Registrar	State of Maryland		ent of Health and ate of Death		giene 07	03163
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	son Du	all		2. Date of De Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, gives  5. Social Security Number 6. Sex	spital Un-	ter Cr	City, Town, or Location of Dea	)	4c. County of Deat	th - hplace (State or Foreign
	Funeral Director			IM 2□F 86	Yrs. Mon		037267	1920	MD
	Maryland f ehow	or	10a. State 10b. County MD KENT		Fown or Location				10d. Inside City LimiIs 1 X Yes 2 ☐ No
	death with the Maryland ime 23a or 28a-f ehow if mital be notified at	i Director	10e. Street and Number 20955 BAYSIDE A	VE.	101	. Zip Code 21661		10g. Citizen of Whal Co USA	untry?
036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mentel Hyglane. Item 27 is marked othar than "natural", or iteme 23a or 28a-f show other traumatic event, the Mudical Exactings must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S. Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Black, White	
Baltimore, Maryland 21215-0036	d within 72 hours after glane. ir than "natural", or Ite the Mudical Examilies	Completed	15. Decedent's Educ (Specify only highest grade	College (1,40r.5+)	(Give kind o	Jsual Occupation f work done during most of w T use retired) MANAGER	orking	16b. Kind of Business/	industry
/land	ould be filed Mentel Hygis arked other atto event, u	To Be C	17. Father's Name (First, Middle, Last) REVERDY BENJAMIN	DUVALL			BENSON	Maiden Sumame)	
, Man	is 1 and 2 should of Health and Men item 27 is marks other traumatic		19a. Informant's Name/Relationship (Tyx. PATRICIA S. DUVALL	/WIFE	20955 B	ress (Street and Number or F AYSIDE AVE.,			
imore	pernit. Pages 1 and Department of Heal Important: if Item 2 any Injury or other 2005.		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cem	e of Disposition etery, crematory SAPEAKE	(Name of or other place)  CREMATORY 01/	Date 22/2007	20c. Location - City or STEVENSVILL	
- Balt	Depart Depart Import any in		21. Signature of Funeral Service License	elfuli	FELI 130	e and Address of Facility OWS HELFENBE SPEER ROAD, C	IN AND N HESTERTO	EWNAM FUNER WN, MD 2162	AL HOME, PA
8760,	bhysician and /Medical Examiner is the purial-transit	dical Examiner	23a. Pant1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	A R R R C (dece of):  16 — R c (dece of):				Approximate Interval Between Onset and Death MINUTCS
.O. Box 6	The law requires thet the death certific sie has been signed by the attending p page 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mortins? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectop	ic pregnancy (specify)		23d. Date of deli Month	ivery Day Year
۵.	quires thet n signed but and be deta	Ď	Part II. Other significant conditions con	tribuling to death bul not resullin	ng in The underlyi	ng cause given in Part I.	23e. Did to	obacco use contribute to	
al Records,		Completed							topsy findings available completion of cause of
Division of Vital	ing Phys After this uneral di	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending 2  Accident investigation	The second second	/Outpatient 3 December 2015   June 2015	Othor		ne) dence 6  Other (Spec now injury occurred	ify)
Divis	tal or Attend s after death al Director; / ed in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	atory, office	28f. Location (S City or Tox	Street and Number or Ru vn, State)	ral Route Number,
	he Hospital or in 24 hours afte he Funeral Dir pletely filled in I	Medical	29a. Certifier 1 Cartifying Phys (Check only one) 1 Madical Examin	ician: To the best of my knowle lar: On the basis of examination and manner stated.	dge, death occur and/or investiga	red at the time, date and plac tion, in my opinion, death occ	e, and due to the curred at the time, c	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	Within 2 complet	Σ	29b. Signature and title of certifier    Have   C.   Gardel   Gard	limon up I	705	29c. License number  D 59287		29d. Date signed (Month TAVUARY	1, Day, Year) 18, 2007
	+ ms		30. Name and address of person who con RAULR - JOHNSON	1mb 100 5	nown	ST. CHOS	Tento	wn, man	41nnn 2/620
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2	32. Register's Signature	1 1	nous .			

			1 - For State Registrar	State of Marylan	d / Depa		lealth and I	Mental Hyg	iene 19. No. 0 0 7	03164		
\$10 m	Physici		1. Decedent's Name (First, Middle, Last Marguerite G. Eat					2. Date of Death Month January	Day 2007	3. Time of Death 2:30 A M		
Y.	/Medio Examin		4a. Facility Name (If not institution, give 5306 Audubon Road			4b. City, Town, o	r Location of Death	1	4c. County of Death			
	Funeral Director		370 32 1203	x ☐ M 2 ☐ F 7. Age (In yrs. 96	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar. 8,	O Birdh	place (State or Foreign		
	show	۲.	Usual Residence of Decedent		y, Town or Lo	cation			10d. Inside City Limits <b>XX</b> /es 2 ☐ No			
	Mith the M a or 28a-f be notifie	Directo	MD Montgome 1  10e. Street and Number  5306 Audubon Road		thesda	10f. Zip Code 208	1.4	1	Og. Citizen of What Cou			
036	urs after death al', or iteme 23 maminer musi	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3XXVidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 23 No If Yes, Give Year or Dates:	,	1	lispanic Origin? (S an, Mexican, Puerl		S.A.  14. Race - Ameri Black, White	, etc.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  any Injury or other treumatic event, I've Heatical Eventinal must be notified at anone.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired epreneur	pation during most of wor d)	king	16b. Kind of Business/Ir	ndustry		
Maryland		To Be C	17. Fathers Name (First, Middle, Last) Albert Travers	ne (First, Middle, M ine Hame]	Middle, Maiden Sumame) Hamelin							
, Mar			19a. Informant's Name/Relationship (T Margaret Elbert/	Daughter	5306	Audubon	and Number or Ru Rd, Beth	esda,MD 2	City or Town, State, Zip Code)			
Baltimore,			20a. Method of Disposition  1 Disposition  2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	ock Cre	sition (Name of matory or other place eek Cem	1-2	0 <b>–</b> 07 <i>V</i>	20c. Location · City or T Vashington	DC		
Balt	Departition Depart		21. Signatur of Fineral Service Lipins Williams K.	Burn				_	ler's Sons			
	Physician /Medical Examiner		23a. Part1. Enter the discusse, or comp shock, or heart failure. List only of Immediate Cause (final disease or condition resulting in death)  Sequentially list conditions.	a. Cerbra1Vaso  Due to (or as a conseq	ular A		ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to introduction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq d								
ROX	the death certifications by the attending phacehold for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnance Other (specify)	y	-	23d. Date of deliv Month	rery Day Year		
Hecords, P	w requires that the deart been signed by the atte should be detached for	þ	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.		pacco use contribute to es 2∑No 3☐Pro			
Hec	the la ate has page 2	Completed	25. Was case referred to medical					24a. Was ar autops perform 1 Yes 2	y prior to connect? death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No		
Vital	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ott		ith Check only on	e) ence 6 □Other (Speci	(hr)		
_	Attending Phy r death. sctor: After this by the funeral of	Certification; T	27. Manner of Death  1 Natural  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 28c. Injui	y at rk? Yes 2 □ No	28d. Describe ho	w injury occurred			
DIV	To the Hospital or Attendit within 24 hours after death. To the Funerel Director: At completely filled in by the fu		4 Homicide determined	building, etc. (Specif	y)	,		City or Town				
	n 24 hou n 24 hou ne Fune oletely fi	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exemone)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the till vestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as a ate and place, and due	stated. to the cause(s)		
	To within	Ä	29b. Signature and title of certifier  Jilbert	Junty M	. D	29c. Licens			9d. Date signed (Month, Jan 15, 2007			
t	Sta	ate.	30. Name and address of person who of Gilbert E. Hurwi 31. Date filed (Month, Day, Year)  JAN 2.2 200	tz,M.D. 1800	T St.	N.W. Wash	nington D	C 20006				

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

State

LINDA M. BURRELL, M.D..

JAN 22

2007

31. Date filed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

SUITE #400, WHEATON, MARYLAND

2730 UNIVERSITY BLVD.,

gistrar's Signature

		1	For State Registrar	e of Maryland / D		rtment of Herificate of L		nd Mer		iene	7 03	166
	. 3		Decedent's Name (First, Middle, Last)				-		Date of Deat		3. Time	of Death
	Physicia	an	Harold Arthur Fis	her					Month Janu	ary 17,	2007 4:	30 <sup>p м</sup>
	/Medic	_	Ia. Facility Name (If not institution, give street as			4b. City, Town, or	Location of	Death	0 4.1.4	4c. County of		
	Examin	er	Washington Adventist				Tako	ma Pa:	rk	Mo	ntgomery	
		- 4	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth (Month, Day,		9. Birthplace (State Country)	
	Funeral Director		165-12-3512 XCIM 20	<sup>3</sup> F 86 Y	rs.	Months Days	Hours			7. 1920	Pennsy1	vania
		<b>⊢</b>	Usual Residence of Decedent									O's at lesite
	yland		10a. State 10b. County	10c. City, Town	or Loc	ation					10d. Inside	s 2 v No
	B-1-	to	Maryland Montgomery	Silv	er	Spring						
	br the	lre	10e. Street and Number			10f. Zip Code			1	0g. Citizen of Wh	nat Country?	
	d within 72 hours after death with the Maryland Jene. r than "natural", or terme 23a or 28a-f ahow the Mudical Examinat must be notified at	Funeral Director	9804 Hedin Drive				903			USA		
	dea	ner	11. Marital Status 12. Was	Decedent Ever in U.S. ed Forces?	13. W	as Decedent of Hi Yes, specify Cuba	spanic Orig n, Mexican	jin? (Specify , Puerto Ric	Yes or No- an, etc.)		- American Indian, , White, etc.	
ထွ	or tto	F	1 ☐ Never Married 2 ☐ Married 1√5	Yes 2 □ No es, Give	ł	☐ Yes 2☐ No	Specify:			Specify.	√hite	
21215-0036	rai',	d by	3 ☐ Widowed 4 ☐ Divorced Year	r or Dates: 1941-44						105 Kind of Bug	/	
2 2	72 h	Completed	15. Decedent's Education (Specify only highest grade comp.		(Give k	ent's Usual Occupa and of work done of ONOT use retired	luring most	of working		16b. Kind of Bus	iness/industry	
7	within ene. then "	Idm		ege (1·4or 5+)						Dadam	. Corrown	mont
2	al Hygier other ti		17. Father's Name (First, Middle, Last)	. Ar	ccnı	tectural.			irst, Middle,	redera Maiden Sumame	al Govern	menc
E L	be fi	Be							nnie W			
Maryland	nd 2 should be filed lith and Mental Hygid 27 ie marked other r traumatic avant, II	P	Arthur Patton Fisher  19a. Informant's Name/Relationship (Type, Prin		Mailin	g Address (Street a	and Numbe				itate. Zip Code)	
Vai	12 st and 7 ie n		19a. Informant's Name/Perationship (1996, Pri			120						
	s 1 and 2 f Health item 27 i		Elizabeth A. Fisher/ 20a. Method of Disposition	20b. Place of	Dispos	ledin Uri sition (Name of		ilver			City or Town, State	
Ö	8 = =		1 Burial 2 ☐ Cremation 3 ☐ Remova	I from State		natory or other plac			22, 20		reves	nen
Ë	t. Pa tmen tant:		4 Donation 5 Other (Specify)	George	anne algres de la companya del companya de la compa	shington	-	margaretta - Commercial	_		Marylan	d
Baltimore,	permit. Page Department of Importent: if eny injury or once.		21. Signature of Funeral Service Licensee	0.	Fr	Name and Address ancis J.	Coll	ins F	uneral	Home In	nc. oring ,MD	20901
	40260		23a. Part1. Enter the disease, or complications	that caused the death. Do r							Approxim	ate
			shock, or heart failure. List only one caus	e on each line.	A	- 1	9,		,		Interval B Onset an	etween d Death
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	and I-tran	xan	that initiated events C.	Oue to (or as a consequence	of):	Croning	7011		71351	Ci ibe i		
8760,	be ey icien buria	al E		Diabetes								
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Вох	atten for u	lan	in the past 12 months?	Live birth 2 Fetal death Pregnant at time of death		Ectopic pregnancy Other (specify)	1			Mon		Year
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L	Jing J. After fune	lon	1 Natural 5 ☐ Pending		Injury	Wor	rk? ∣Yes 2. 🗆	No				
:0	death ctor:	Ca	3 Suicide 6 Could not be	. Place of Injury - At home, fa	arm. str	eet, factory, office		28			er or Rural Route N	lumber,
Division	or A after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)					City or Tov	vn, State)		
_	pital ours erai filled	O	29a. Certifier 1. Certifying Physician	To the best of my knowledge	e, deat	h occurred at the til	me, date ar	nd place, an	d due to the	cause(s) and ma	nner as stated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: 0	n the basis of examination and manner stated.	nd/or in	vestigation, in my o	opinion, dea	ath occurred	at the time,	date and place, a	ind due to the caus	e(s)
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	10+1		30. Name and address of person who complet		(Туре.		100			(	· · · · · · · · · · · · · · · · · · ·	
				7600 Carroll			oma Pa	ark. M	D 2091	12		
	St.	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature								
3	Regis		JAN 2 2 2007	Kline &	Son	الكلما						

		-	For State Registrar	State of Maryland		rtment of H			giene	007	03167		
			Decedent's Name (First, Middle, Last,	)				2. Date of Dea	ath Day	Year	3. Time of Death		
	Physicia		Heather Anne Fie	alding				Month Januar	•		6:00 aM		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death			ounty of Death			
	<b>EXAMINIT</b>	er	Montgomery Genera			0.	lnev			Mon	tgomery		
-	Funeral		Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birth	nplace (State or Foreign intry)		
	Director		220-13-2082	<sup>3 M 2</sup> √ <sub>2</sub> F 28	Yrs.	Months Days	Hours Wist.				ington, DC		
-	0		Usual Residence of Decedent		_						10d. Inside City Limits		
	ehow		10a. State 10b. County	10c. City	, Town or Lo	cation			1 Yes 2 📮				
:	B Ma	cto	Maryland Montgome	ery	Roc	kville							
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiza	en of What Cou	untry?		
	within 72 hours after death with the Maryland jene. "then" natural", or Itema 23s or 28s-f show the Madical Examiner must be instiffed at		4833 Bel Pre Roa			20853				USA	in the discount of the second		
	dea r	Funerai	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S) n, Mexican, Puert	pecify Yes or No o Rican, etc.)	.   1	<ol> <li>Race - Amer Black, White</li> </ol>			
õ	or it		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		5	<sup>Specify</sup> Whit	e		
5-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:			ation			d of Business/I			
ភ្ន	nati	Completed	15. Decedent's Edu (Specify only highest grad	de completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	TOD. INIT	0 01 00311103371	ridustry		
2	within 72 ene. then 'na'	d L	Elementary/Secondary (0-12)	College (1-4or 5+)						27/2			
N	Hygie other		17. Father's Name (First, Middle, Last)			[ever Wor	18. Mother's Nan	ne (First, Middle,	Maiden S	N/A Sumame)			
ä	d ta b	Be		i al dina			Tind	a M. Gri	moc				
Maryland	should be nd Menta i marked umatic ev	2	Graham Patrick F: 19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street				Town, State, Z	lip Code)		
<u>8</u>	d 2 sho th and 7 is m treum		Linda Rae Marref/			Winding							
αĵ	s 1 end 2 shou f Heelth and M Item 27 is mar other treumat	li	20a. Method of Disposition	20b. Pf	ace of Dispo	sition (Name of		Date		ation - City or			
altimore,	00		P☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	natory`or other plac .n's Ceme:	tory Jan.		same and	status sua estat.	A 250240000 VIOLENT VIOLE		
<b>#</b>	permit. Pag Department Important: f any injury o		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service) I cens								Maryland		
Ba	Depa Impo any i		21. Signature of Purietal Service Cons	Sucha		rancis J							
			222 Part Enter the disease or comp	dications that caused the death	Do not ent	er the mode of dvir	rsity Blv no. such as cardiao	or respiratory a	SILVE rrest,	er Spri	ng, MD 20901 Approximate		
			23a. Part1. Enter the disease, or compositors Course (Final								Interval Between Onset and Death		
æ	nysician		Immediate Cause (Final disease or condition resulting in death)	u	RITOR	41 TI \$					2 DAYS		
	/Medical Examiner		1	Due to (or as a consequ			2 -0 5 40	0	1.0				
ы		_	Sequentially list conditions,	b. Due to (or as a consequence)		EL OR	PERFOR	4/60 10	000 52				
	ed ist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 00 0 0000000	0.100 0.,.								
	and and I-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):								
760,	Attending Physician: The law requires that the death certificate be executed refath.  reath.  sctor: After this certificate hes been signed by the attending physicien and story the funeral director, page 2 should be detached for use as the burial-transit by the funeral director, page 2.	ical											
387	phys phys s the	9		d									
9 ×	eath certific attending p	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregna					2	3d. Date of del	ivery		
Box	atter for u	cia	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	/			Month	Day Year		
P.O.	the d	ysic	1 □ Yes 2 ②No 9 □ Unknown	9□ Unknown									
۵.	that the death hed by the atter detached for u	a d	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?		
ds	uires t signe ld be	d by	MENTAL RETARI	PATION GAST	ROINT	ESTINAL		1 🗆	Yes 2	No 3□Pr	obably 4 Unknown		
Ö	w require been si	Completed	BLEEDING					24a. Was		24b. Were au	itopsy findings available		
Re	he lav	E D	BCCENIAG						ormed?	death?	completion of cause of		
a	ysician: The is certificate he director, page	CO	25. Was case referred to medical				26 Pince of De	1 ☐ Yes ath (Check only	2 No	1 L Yes	2□ No		
₹	sicis	00	examiner?	Hospital: 1 ■Inpatient 2 □	EP/Outpatio	nt all DOA Ott		dam one 5 ☐ Res		□Other /Soe	city)		
ō	Phy r this rald	5	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			0.1)		
on	ding th. Afte	Ş	1 Statural 5 Pending 2 Accident investigation		Injury		rk?  Yes 2∐No						
Division of Vital Records,	dea dea ctor	fica	3 ☐ Suicide 6 ☐ Could not be	286. Place of injury - Acric	ome, farm, st	reet, factory, office		28f. Location	(Street and	Number or Ri	ural Route Number,		
ă	efter Dire	Certification;	4  Homicide	building, etc. (Specif	y)			City of To	wii, Siate)				
	To the Hospitel or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral directors.		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno	wiedge, dea	th occurred at the ti	me, date and plac	e, and due to the	cause(s)	and manner as	s stated.		
	Ho 124 h	edicai	(Check only 2 Medical Exen	niner: On the basis of examina and manner stated.	ition and/or in	nvestigation, in my	opinion, death occ	urred at the time	date and	place, and due	to the cause(s)		
	To th To th somp	Me	29b. Signature and title of certifier			29c. Licen:				signed (Mont			
	1		Dr. Literal	Heler- Hour	Louz	0009	58542		JAN	UARY	16, 2007		
	•		30 Name and address of person who	completed cause of death (Item	n 23a) (Type	, Print)		15	4		16, 2007 EATON, MD		
			DR. LIBUSE HEINZ	- MOMCILOV	10,11	SUI GEO	KGIA A	VENUE	# > 1	1 20	302 , 1913		
	St	ate	31. Date filed (Month, Dey, Yeer)	32 Registrar's Signa									
4	Regist	rar	JAN 22 201	there is	-	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DAVID RANDALL GRIZZLE JANUARY 26 2007 12:55P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | September 16, 1951 7. Age (In yrs. last birthday)
55 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 233-80-6303 1 M 2 □ F West Virginia **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Frederick Director Point of Rocks 1 ∑Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1755 Canal Run Drive 21777 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. TYPes 2 Jan. 1970 if yes, Give Jan. 1970 Year or Dates jan. 1974 1 Never Married Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cruise Director Tourism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heyward H. Grizzle Dora Elizabeth Young 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Clarke Grizzle/Wife 1755 Canal Run Drive, Point of Rocks, MD 21777 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Method of Disposition

1 Burial 2000 remation 3 Removal from State Smithsburg Crematory Jan. 29, 2007 Smithsburg, Maryland Pathre of Juneral Service Ricenside 22. Name and Address of Facility Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that paysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) .C. 1300 Approxi a e Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 troke day /Medical cell lynn Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à monary 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was an autopsy performed a No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

certificate be executed Box 68760, P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore.

burial-tran and physician the as attending nse ģ ed by the a signed to peen has page 2 certificate director, this funeral After t Hospital or Attending thin 24 hours after deau...

o the Funeral Director: Af

0

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

E

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elhamy

skander, MI

32. Begistrar's Signature

31. Date filed (Month, Day, Year)



		1 - State of Maryland > Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No.	_ 0 0 1	03169
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  Ruth Marie Hagenbuch  2. Date of Death Month Day  Annual V		3. Time of Death
Examine			County of Death	and .
Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan 18 1922	9. Birthplace Country Maryla	e (State or Foreign
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Rel Air 522 Thomas Run Rd. Bel Air, MD	10d.	Inside City Limits 1   Yes 2   No
with the	i Director	10e. Street and Number 522 Thomas Run Rd 10f. Zip Code 21015 US	izen of What Country	?
21215-0036  Within 72 hours after death with the Maryland iene. I then "natural", or itame 23s or 28s-1 ehow the Medical Examinar must be redified at	by Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Never Married 2 Married 1 Yes 3 No	14. Race - American Black, White, etc. Specify: Whit	
215-0 nin 72 hi on "natu We alco	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired)	nd of Business/Indus	try
	Com	12 Teacher's Aide E  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden S	Education	
Maryland 21215-0036 at 2 should be filed within 72 hours aft the and Mental Hygiene.  27 Is marked other then "natural", or traumatic event, the Medical Exercitivations and the contraction of the contractions are contractions.	To Be	Roy Sturtz Mabel (Coughenour)	Sturtz	
Mar and 2 sh alth and 27 ts m		19a. Informant's Name/Relationship (Type, Print)  Stephen Hagenbuch  Son  19b. Mailing Address (Street and Number or Rural Route Number, City or 2108 Wentworth Dr. Bel Air, MD 2	r Town, State, Zip Co 21015	de)
Baltimore, Maryland 2 permit. Peges 1 end 2 should be filed Depertment of Health and Mental Hyg Important: If Item 27 is marked other ery injury or other traumatic event, once.		1 ₩ Burial 2 Cremation 3 Removal from State	cation · City or Town, Derland, M	
Balt permit. Depert Import eny in]		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral 1302 National Hwy., LaVale, MD		PA
Pnysician /Medical		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock) or heart failure. List only one cause on/each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Int	proximate erval Between nset and Death
fitcate be executed physicien and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		
Box 6 death certifications at for use as	Physician/Me	FFEMALE:   23b. Was decedent pregnant   in the past 12 months?   1	23d. Date of delivery Month Da	y Year
, s es	۾	- 111 A SOUL OF	se contribute to the c ☑No 3 ☑ Probably	
If Record The law requirelese has been sipage 2 should	Completed	24a. Was an autopsy periomed?	24b. Were autopsy prior to comple death?	
buc.  of Vital F  Physician: Th  this certificate ral director, pag	To Be (	25. Was case referred to medical examiner?  1   Yes   2   No	Clother (Secreta	
on of oding Physics : After this internal dial		27. Manner of Death    28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury   28d. Descri		
Hagenbury  Division of Vita  To the Hospital or Attending Physician: within 24 hours elfer death. To the Funerel Director: Affer this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)	d Number or Rural Ro	oute Number,
To the Hospital within 24 hours 6 To the Funerel I completely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) at 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	and manner as stated place, and due to the	d. e cause(s)
To t To t com	Σ	Thanses A. Brondo MD 842800 11	e signed (Month, Day	, Year)
8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Howa 5 A 50000 MS 319 South Callot My 1400	preff X.	1079
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2007		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs Months Days Hours Min.

Sandy Spring

Heidel

7. Age (In yrs. last birthday,

93

Ethe1

1 M 2 X X

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Sharon Yang, M.D

JAN 2 2 2007

31. Date filed (Month, Day, Year)

4a. Facility Name (If not institution, give street and number)

Brooke Grove Nursing Home

Day

2007

4c. County of Death

MD 20906

Montgomery

Montana

Jan.\_19,

Date of Birth (Month, Day, Year)

Feb. 1, 1913

 $a^{M}$ 

5:50

Birthplace (State or Foreign Country)

Physician /Medical Examiner
Funeral Director

Tommie

5. Social Security Number

213-48-2223

Usual Residence of Decedent

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be positional once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10

10a. State 10b. County 10c. City, Town or Location 10d. Insid									
Maryland Montgomery Silver Spring  10e. Street and Number 10f. Zip Code 10g. Citizen of What Court 20906									
10e. Street and Number 3122 Adderly (			10f. Zip Code 20906	100	g. Citizen of What Co U	ountry? SA			
11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 Yes 2 1 No If Yes, Give Year or Dates:		I as Decedent of Hispanic Origi Yes, specify Cuban, Mexican, ☐ Yes 2☐ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White				
15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)	(Give ki	nt's Usual Occupation ind of work done during most of NOT use retired)	of working	6b. Kind of Business	/Industry			
17. Father's Name (First, Middle, La	4 est)		School Teache 18. Mother	s Name <i>(First, Middle, Ma</i>	Educat aiden Surname)	tion			
Thomas Richardso	on		Am	anda Honsin	ger				
19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing	Address (Street and Number	or Rural Route Number,	City or Town, State, a	Zip Code)			
Sumner G. Heide	e1/Husband	3122 F	Adderly Court,	Silver Spr	ing, MD 20	0906			
20a. Method of Disposition  12 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State		tion (Name of atory or other place) eaven Cemetery	Jan. 23,	oc. Location - City or Silver Spi	Town, State			
21. Signature of Funeral Service En	Scalo	Fra 500	Name and Address of Facility ancis J. Colli University B	ns Funeral i	Home Inc.	3.			
23a. Part 1. Enter the disease, or of shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any learning the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	a. Advanced De Due to (or as a conseq b. Congestive Due to (or as a conseq c. Anorexia Due to (or as a conseq d. 23c. If yes, outcome pf pregna	ementia quence of):  Heart F quence of):	Failure	ardiac or respiratory arres	23d. Date of de	Approximate Interval Between Onset and Death			
in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 5 □ 0	Ectopic pregnancy Other (specify)		Month	Day Year			
Part II. Other significant condition	s contributing to death but not res	ulting in the und	lerlying cause given in Part I.	23e. Did toba		o the cause of death?  robably 4  Unknown			
				24a. Was an autopsy performe 1∐ Yes 2∮	prior to death?	utopsy findings available completion of cause of 2 II No			
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient		of Death Check onl one sing Home 5 ☐ Residen		city)			
27. Manner of Death  1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  27. Manner of Death 5 ☐ Pending investigat 6 ☐ Could no determin	be 280 Place of injury. At he	28b. Time of Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred  et and Number or Ru				
29a. Certifier (Check only one)	Physician: To the best of my kno caminer: On the basis of examina and manner stated.	owledge, death of	estigation, in my opinion, death	place, and due to the cau	ise(s) and manner as	s stated. e to the cause(s)			
29b. Signature and title of certifier	12	Y	29c. License number	6 290	d. Date signed (Mont	h, Day, Year)			

State

Registrar

3305 N. Leisure World Blvd., Silver Spring,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 8:55P M HAMPTON SYBIL lanuary ZOUT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner a Plata 1015 ta Medical har tos enter If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03-01-1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days WEST VIRGINIA Yrs 176-56-2683 Director 84 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits rai", or items 23a or 28a-f show Examiner must be notified at WHITE PLAINS 1 ☐ Yes 2 No Director MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or it in any injury or other traumatic event, the Medical Examiner must be none. 4710 OAK STREET 20695 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be JOHN WILLIAM PENNINGTON BERTIE WYLIE မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN J. HAMPTON - SPOUSE 4710 OAK ST., WHITE PLAINS, MD 20695 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JANUARY 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State TRINITY MEM. GARDENS 23, 2007 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MARYLAND 21. Signature of Fungral Service 22. Name and Address of Facility M00053 HUNTT FUNERAL HOME 3035 OLD WASHINGTON RD., WALDORF, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 0 5 **Physician** /Medical Due to (or as Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the the as attending p for use as IF FEMALE: if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 s autopsy perform certificate 2 12 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 □ Yes 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 1/2001

Medical

State

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Sons

and manner stated.

32. Prigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hon MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Cenna Medica Center 76 Post Office Rd. Walder

MD 20602

			For State Registrar	State of M	Maryland /		artment of tificate o		and M		giene	2007	03172
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Maryland 21215-0036	within 72 hours after ene. than "natural", or ita	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gra	If Yes, Give Year or Dates ducation ade completed)	1	6a. Deced	lent's Usual Oc kind of work do DO NOT use re		t of workir	ng		Specify: W	hite //ndustry
and 212	be filed tal Hygi d other avant, I	Be	Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last John R. William	,	(5+)	Cafe	teria		r's Name	(First, Middle,		od Ser	vices
	is 1 and 2 should of Health and Men Item 27 is marks other traumatic	<b>1</b>	19a. Informant's Name/Relationship ( Kathleen Wagne	Type, Print)	ghter)	111	27 Car	eet and Numbe	or or Rura Clar	Route Number	Ga]	lena,	MD. 21635
Baltimore,	permit. Pages 1 Department of H Importent: If Ita any injury or ott		20a. Method of Disposition  1	nede	Sun	set	Name and Ad	al Pk	1/2		Fea		ille, PA. L. Schaec. 21635
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	rate be executed by sicien and ine burial-transit and	dical Examiner	Sacuentally list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequent	ce of):							
O. Box 6	the death certific the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown		2 Fetal death	ath 3 🗌	Ectopic pregna			557,1	2	3d. Date of de Month	ivery Day Year
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	1115		30. Name and address of person who Susan K. Ross 31. Date filed (Month, Day, Year)	s, M.D.		ashi		Ave.	Che	sterto	wn,	MD. 2	21620
	Sta Registr		JAN 2 4	2007	strars Signature	× A	book						

			State of Maryland						03173
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Exam		4a. Facility Name (If not institution, give st	1			Location of Death		4c. County of Deal	1
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Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign
Directo	r	Usual Residence of Decedent	76				SEPT. 7	930	147
land ow		10a. State 10b. County	10c. City, T	Town or Loc	ation		-		10d. Inside City Limits
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dea	ner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
or It	Y.F.	1 Never Married 2 Married	1 □ Yes 2 No If Yes, Give Year or Dates:	1	☐Yes 2 No	Specify:		Specify:	HITE
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id be ental	To Be	WILLIAM FREDE	rick Huck			LIL	LIE E.	ZENKE	-
should be nd Mental marked o	-	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rui	ral Route Number. C	ity or Town, State,	Zip Code) 2/623
re, Maryla s 1 and 2 should f Health and Men tlem 27 la marke other treumatic		Julie H. BE	DELL (Sister)	300 B	OSPECY	CHURCH	Date 20	12CH 17166	,, MD 21003
		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Re	20b. Plac						
		1 ☐ Burial 2 Mg Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	CHES	SAPEAK	E CREMA	Tony 1/3	23/07 (	HESTER	MD.  TOWN MD  ZIEZO  Approximate
Daltim permil. Pag Department Importent: any injury	i dici	21. Signature of Funeral Service Licente		22.	Name and Address	ss of F cility	I WAY (	2HESTER	TOWN MD
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/Medica Examine		resulting in death)	Due to (or as a consequer						
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BOX 687 (leath certificate be attending physical for use as the better the tree as the better the b	edic								
BOX bath cert attending for use a	Z	IF FEMALE: 23 23b. Was decedent pregnant 23	c. If yes, outcome of pregnance		Ectopic pregnancy			23d. Date of de	livery
. 0 00	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of deat		Other (specify)			Month	Day Year
at the lby th	hys	9 🗆 Unknown	9LI ORKNOWN						
IS, F.O. I	by	Part II. Other significant conditions con	ributing to death but not resulti	ing in the ur	nderlying cause giv	en in Part I.		. *	the cause of death?
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ne Ho ne Fu stetely	edical	(Check only f Medical Examin	er: On the basis of examination and manner stated.	n and/or inv	estigation, in my o	opinion, death occu	rred at the time, date	and place, and due	e to the cause(s)
To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens	e number	290	Date signed (Moni	-
		1/an 100	la - m	~	DI	64 88		1-22-	0.1
5		30. Name and address of person who con	npleted cause of death (Item 2	23a) (Type,	Print)	01		.00.1	01/03
NIS		31. Date filed (Month, Day, Year)	32. Registar's Signatur	WN.		C WEOTH	rtown,	MIG.	21620
Regi	State strar	JAN 2 4	2007	J. S.	Soul !				

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	Dharais		1. Decedent's Name (First, Middle, Last)				2. Date of D			3. Time of Death
	Physic /Medi		Irene Justin Hagg				Januar	ry 21, 2	Year 2007	5:50 P M
	Exami		4a. Fecility Name (If not institution, give street and no	umber)		, or Location of Dea				
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ı	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birthda) 93 Yrs.	Months Day			irth Day, Year) L, 1913	Cour	place (State or Foreign
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	how	1.	10a. State 10b. County	10c. City, Town or I	ocation				1	IOd. tnside City Limits
	e Ma	cto	MD Howard	Columbia						1 ☐ Yes 2 No
	with th	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
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ž	hould d Mer mark	10	19a. Informant's Name/Relationship (Type, Print)			Emma Sei		1		
<u>s</u>	d 2 s Ith an 27 ia i		Alice Morgan/daughter			et and Number or Ru				
<u>6</u>	Heal Heal Heal	1 //	20a. Method of Disposition	20b. Place of Disp	osition (Name of	Patuxent	Pkwy. C			
Ë	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)			ı		20c. Location	-	
altimore,	mit.		21. Signature of Funeral Service Licensee	Chesapeak	e Cremat 2 Name and Addr	ory 01/2	2/07	Beltsvi	lle, N	1D
m	8858	1 1	Dever & Hattle	MO1251Re	ing Home	essof Facility Crematio	n Servi	ce P.O	· Box	784
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	r Att	Certification;	3 Suicide 6 Could not be determined 28e. Place building	of Injury - At home, farm, string, etc. (Specify)	eet, factory, office		28f. Location (S	Street and Numb	er or Rural I	Route Number,
ב	rai D						City or Tov			
	Hosp 24 hou Funa tely fi	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Exeminer: On the band mann		occurred at the til	me, date and place,	and due to the	cause(s) and ma	nner as stat	ted.
	To the Hospital or Attanding Physician: The within 24 hours after deeth. To the Funeral Director: After this certificete h completely filled in by the funeral director, page	_	one)  29b. Signature and title of certifier	er stated.						
	⊢ ≯ F 8			1	29c. Licens	e number		29d. Date signed	Month, Da	ay, Year)
10	)n2	-	30. Name and address of person who completed cause	of death (learn 220) Ti	177	542V		1/22/	07	
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DHMH 17 Rev 1/2001

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Director		Unknown	<b>№</b> 2 F	, yre. ide. bir		ths Days			1/23/	,	Foreign Count	
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Baltimore, MD 21215-0036  germir Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important of Health and Mental Hygiene Important: If tiem 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		16507 Governo				716				SA	<del></del>	
eath wi	Funeral	11 Marital Status 1 Never Married 2 Marri	12. Was Decedent Even Armed Forces?		13. Was Deced					14 Race White		n Indian, Black,
after d al", or	by Fi		ed If Yes, Give Year or Dates:			2 🔏 No				Specify:	Blac	ck
hours natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed College (1-4 or 5+)		Decedent's Usua during most of wo				done	16b. Kind of Bus	iness/Ind	ustry
036 ithin 72 ne r than redical	Completed	0	33113g5 (1 1 51 51)									
MD 21215-0036 42 should be filed within 7th and Mental Hygiene n 27 is marked other than umatic event, the <u>Medica</u>		17. Father's Name (First, Middle, La Michael Andre		,		I .				aiden Surname)		
212' uld be Mental marke	o Be	19a. Informant's Name/Relationship			. Mailing Addres				Willi Route Numb		n, State, Z	ıp Code)
MD d 2 sho th and a 27 is numation		Michael Howar	d / Father	. 1	6507 G	ioven	non.	s Bri	idge R	d. Bown	ie M	D 207 16
ore, es   an of Heal If iten her tra		20a. Method of Disposition  1   X   Burial   2   Cremation	Removal from State	cremat	f Disposition (Na ory or other place	e)				20c. Location -	•	
Baltimore, permit Pages   an Department of Hea important: If iter		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic	,	Ressu	rection				/2007	Clinto	n, 1	1D
Bal permi Depar Impo injur		And To have	lein		Dunn	& So	n A F	, 5635	Eads	SENE W	ash	20019 DC
Physician		23a. Part I. Enter the disease, or confaiture. List only one cause on		death. Do no	t enter the mode	e of dying,	such as ca	ardiac or res	spiratory arres	st, shock, or hea	rt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Sudden unex 1		ath in in	nfancy					-	Death
		Sequentially list conditions,	b.	Brice Or).								
	Examiner	if any, leading to immediate course. Enter Underlying Course	Due to (or as a consequic.	ence of):								
ed sit	Exam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):								
evecute an and al - trar		Unpended #23a,27,28	d	6 1.121								
ox 68760, eath certificate be eve attending physician or use as the burial	Physician/Medical	IF FEMALE:	23c. If yes, outcome							23d Date of	delivery	
Box 68760 e death certificate be the attending physical for use as the bu	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time	e of death	==		Ectopic	c pregnancy		Month	Day	Year
Box e death the attr	hysi	1 Yes 2 No 9 Unkno	9Onknown									
cords, P.O. Bot law requires that the de has been signed by the 2. should be detached fi	by P	Part II. Other significant condition	s contributing to death bi	ut not resulting	g in the underlyin	ng cause g	iven in Pa	art I.				e cause of death?
ds, equires	eted							- 3	24a. Was ar	24b V	/ere autop	osy findings available
Recor The law 1 cate has b	Completed					<u> </u>			autopsy perform 1 ✓ Yes 2	ned? d	eath?	npletion of cause of
tal Rection: The certificate	O I	25. Was case referred to medical						(Check only		140	<b>✓</b> Yes	2 No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death.  The rate death.  All Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detact	To B	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 <b>V</b> ER/O		,		Nursing He		esidence 6	Other:	
on of on of on the control of the co	ion:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		Fime of Injury	l	ryatWork ∕es 2 🟋		unk	ow injury occurre	€d	
Division pital or Attene ours after death eral Director:	ficat	2 Accident Investig 3 Suicide 6 X Could n	ation FRG 1/24/2		l 6:00 am rm, street, factor					reet and Number	r or Rural	Route Number, City nor Bridge Rd
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determi		d in res	sidence			Ar	Location (St or Town, Sta napolis	, MD OOU/	Govern	ior prirade ka
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Gridon Grid)	ician: To the best of my kiner:On the basis of examin	_								:ause(s)
To the within To the comple	Med	29b. Signature and title of certifier	and manner stated			9c.License				29d Date signe		

State 31. Date filed (Month, Day Xac) Registrar

Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

January 25, 2007

30. Name and address of person who completed cause of death (Item 23a)

		For State Registrar	State of M		partment of I ertificate of			iene () () 7	03176
Dhoolai		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day Ye	3. Time of Death
Physici /Medic		Franklin Terril					Jan.	23 2007	0.14
Examin	er	4a. Facility Name (If not institution, gir		)	4b. City, Town,	or Location of Dea	th	4c. County of D	eath
		Julia Manor Nurs		ne /la .wa lant hinth		rstown If Under 24 Hrs	S O Data of Dist	Washir	
Funeral Director			1 <b>X</b> M 2□F	ge (In yrs. last birthd Yrs	Months Days		. (Month, Day,		Birthplace (State or Foreign Country)
		Usual Residence of Decedent		70			Feb. 26	1936 M	ississippi
rylan how		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
e Ma	cto	Maryland Washin	gton	Ная	gerstown				1X Yes 2 □ No
vith th	Dire	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
s 23e	rai	428 W. Franklin		Service 110	217		2K-VN-	USA	and the second second
ter de	Funeral Directo	11. Marital Status  1 ☐ Never Married 2 ☒ Married	12. Was Decedent Armed Forces:	No.	<ol><li>Was Decedent of If Yes, specify Cub</li></ol>	pan, Mexican, Pue	rto Rican, etc.)		merican Indian, /hite, etc.
urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 Y Yes 2 □ If Yes, Give Year or Dates:	1953-56	1 ☐ Yes 2 <b>X</b> No	Specify:		Specify:	White
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland all the lygiene. A latent all dither than "natural", or items 23a or 28a-f show of other than "natural be notified at event. In a Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. De	cedent's Usual Occu	pation	arkina	16b. Kind of Busine	ss/Industry
ithin ith	npie	Elementary/Secondary (0-12)	College (1-4or	5+) (iif	ive kind of work done e. DO NOT use retire	nd)	nking		
led w her th		12	0	M	lechanic			Automobil	e Repair
be fi	Be	17. Father's Name (First, Middle, Las.	,				me (First, Middle, N		
ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mendler Hygiene.  If item 27 is marked other than *natural; or items 53a or 28a-f show or other traumatic event. It a Madical Examinat must be notified at	스	Unknown 19a. Informant's Name/Relationship	(Type Print)	10h 14	ailing Address (Stree	Azzie	(unknow		- 7i- Cadal
s, IVICA and 2 s ealth an m 27 is i									
Heal Heal		Shirley A. Jones 20a. Method of Disposition	- wire	20b. Place of Di	W. Frank sposition (Name of			SCOWN Md	
Pages tment of I tant: If its		1 🔀 Burial 2 □ Cremation 3 [ 14 □ Donation 5 □ Other (Speci			awn Mem.	1	5 / O 7 T	Internation	m Marriland
그 등은 중 .		21. Signature of Funeral Service Lice			22. Name and Addre		Minnich l		n, Maryland
Depa Impo any it		Fred L.V	Central		415 E. W1	lson Blve			
2.50 PM		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause	d the death. Do not		21212			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	0	emonia					Onset and Death
/Medical		resulting in death)		a consequence of):	,				- EU WILL
Examiner		Sequentially list conditions.	b						
sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Disease or injury.	Due to (or as	a consequence of):					
ecuta and I-tran	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
cate be executad physician and the burial-transit				a sonosquenos on).					
ficate ficate phys s the	Physician/Medical		_ d.		71.50				
w requires that the death certific been signed by the attending planded by detached for use as t	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	delivery
death death de atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a		3 □Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Year
by th	hys	9 Unknown	9∐ Unknown						
gned gned	by F	Part II. Other significant conditions	contributing to death b	out not resulting in th	e underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
equir sen si ould							1 🗆 Ye	s 2□No 3□	Probably 4 Unknown
law ras be	ompleted						24a. Was ar		autopsy findings available to completion of cause of
The cate h	Con						perform		.?
ician	Be	25. Was case referred to medical examiner?	Hospital:		0.1		ath (Check only one		
Phys this	2	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju		Herit 3 DOA		Home 5 Resider		pecify)
After fune	tion	1 Natural 5 ☐ Pending	(Month, Da	y Year) Injur	y Wo	rk?  Yes 2 □No	28d. Describe hor	w injury occurred	
Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	jury - At home, farm,			28f. Location (Str	eet and Number or	Rural Route Number,
s after	Certification:	4 ☐ Homicide determined	building, et	tc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		
To this Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Pl	nysician: To the best	of my knowledge, de	eath occurred at the ti	me, date and place	e, and due to the ca	use(s) and manner	as stated.
ths H in 24 the Fi	ledicai	one) 2 Medical Exa	miner: On the basis o and manner st	ated.	investigation, in my	pinion, death occi	urred at the time, da	te and place, and d	ive to the cause(s)
To t Com	Σ	29b. Signature and title of certifier	1 Min	A	29c. Licens	se number	29	d. Date signed (Mo	onth, Day, Year)
		mungen	1-1000	-	$\mathcal{P}$	28765		1-23-	. 07
611.2.1		30. Name and address if person who	completed cause of	ath (Item 23a) (Typ	oe, Print)	11 -1 0 - 1	graph a	0 2 /2/	(2)
5H-3+1		31. Date filed (Month, Day, Year)	32 Registr	768 WILL	e street	Helgest	eru 17	1) 4/19	
Sta Registr		29b. Signature and title of certifier  June 1  30. Name and address f person who  AN 2 An - 3  31. Date filed (Month, Day, Year)	007 Janes	as B. Ja	pull				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Robert 1810 PM Samue1 King 28,2007 SANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)Pennsylvani 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2□F Hours Director 217-30-5949 July 3, 1933 Waynesboro Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11455 Englewood Road 21740 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Stock Clerk Ribbon Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George H. King Cora Pear1 Smith ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Marie King / Wife Englewwod Road Hagerstown Maryland 21740 1145 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery |2/01/2007 Hagerstown Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Mark Su 1601 Pennsylvania Ave Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician consente disease or condition resulting in death) ian /Medical Due to (or as a consequence of): **Examiner** Inclimic Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed com the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) ned by the all 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hozentijeiden 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed! Yes 2 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 No ၉ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation s after dea.. ral Director: Aft 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

44 State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FEB 0 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAT

120 MD



MO

Registrar

29c. License number

MILL

D18019

29d. Date signed (Month, Day, Year)

MAGERSTOWN MID 21740

JAN 24 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 07-00592 James Knight

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	1- For State Certificate of Death Reg. No.													
Physicia dical Exami	n/	Decedent's Name (First, Midd     JAMES EDWA)		T						Date of Dea Month January 2	Day	Year	3	Time of Death 2205 hrs
		4a. Facility Name (if not institution 27 Yankee Drive			- 4	b. City, Tow Keedys		ocation of [			4c. C	ounty of Cashingto		
			C C	7. Age (In yrs, las	nt histholous	If Under		If Under 2	24455	Date of R				place (State or
Funeral Director		5. Social Security Number	6. Sex		•	Months	Days	Hours	Min.		<b>(</b>	F	oreign	
Birector		266-19-9579	1 X M 2 F	51	Yrs.					JULY '	13, 1	955	Court	tryFLORIDA
è	- 1	Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Locati	on							1	Od Inside City Limits
10 W a			LITHOTON				VEE	DYSVI	1115					1 X Yes 2 No
ryland a-f st	흸	MARYLAND WAS	<u>HINGTON</u>			10f. Zip Co		DISVI			10g. Citize	n of What	Countr	y?
or 28	Director	27 YANKEE DRIV	С					2175	56			11	.S.	Δ
eath with the Maryland items 23a or 28a-f show any ust be notified at once.		11. Marital Status		cedent Ever in U.S		s Decedent		anic Origin	n? (Speci		0- 14	Race - /	America	n Indian, 8lack,
leath r item	Funeral	1 Never Married 2 X M	Armed F	orces?	If Y	es, specify (	Cuban, I	Mexican, P	Puerto Ric	can, etc.)		White, e	etc.	
after de	by F	3 Widowed 4 Div	vorced If Yes, Give Ye		1	Yes 2 X	No	specify:			S	pecify:	WH	ITE
ours a	힣	15 Decedent's Education (Spe			16a. Deceden	it's Usual Oc ost of working					16b. Kın	d of 8usir	ness/Inc	lustry
6 n 72 h	ete	Elementary/Secondary (0-12)		1-4 or 5+)			J				, , ,		. T	UE ADMY
5-0036 led within 7 Hygiene I other than	Completed	17. Father's Name (First, Middle	5	+	SENIO	4 R021				irst, Middle,			P	HE ARMY
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once	ادہ	JAMES EDWARD K								JOHN		arriorrio,		
5 5 6 d 2	o B	19a. Informant's Name/Relation			19b. Mailing	Address	_					or Town,	State, Z	Zip Code)
MD d 2 shot lth and n 27 is numation	-1	SANDRA KNIGHT/	SPOUSE		27 Y	ANKEE	DRI	VE, K	KEEDY	SVILL	E, MA	RYLA	ND	21756
- c @ - C		20a Method of Disposition			lace of Dispos		of ceme	etery,	C	)ate	20c. Lo	cation - C	ity or To	own, State
MOF Pages nent of ant: If		1 X 8urial 2 Crematio 4 Denation 5 Other S	n 3 X Removal f	TOTT State	e Oak		1737		1/27	7/07	Tive	o Oak	- F	lorida
Baltimore, permit Pages 1 a Department of He Important: If it in injury or other to		21. Signature of Funeral/Service	Licensee		22. N	Name and A	dress		7	7606 0				
E E E		TOWN		ul M. De		ST FUN			VIE P	Roonsh	oro.	Mary	lan	
Physician		23a. Part I. Enter the disease, of failure. List only one cause		caused the death.	Do not enter t	he mode of	dying, s	uch as car	rdiac or re	espiratory a	rrest, shock	k, or heart		Approximate Interval 8etween Onset and
/Medical :xaminer		Immediate Cause (Final diseas		unshot Woun										Death
- 24		or condition resulting in death)	Due to (or as	a consequence of	):									
	ler	Sequentially list conditions, if any, leading to immediate	·	a consequence of	·):									
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	С.	a consequence of	· ·								_	
ansit	Ĕ	events resulting in death) Last	d d	a consequence of	).									
Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be executed within 24 bours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	n/Medical	UNPENDED	AMENDED											
8760, tificate be ng physici as the buri	₩.	IF FEMALE: 23b Was decedent pregnant in		, outcome of pregr		-1-1-111-	3	Ectopic	pregnanc			Date of d	eli <b>ve</b> ry Da	ay Year
certification of the control of the certification o	ciar	past 12 months?	LITIVE	nant at time of de	ath _	etal death ther (Specif	- 1_	Ectobic	pregnanc	У		TOTAL	Da	y real
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 U	nknown 9 Unk	nown		(12)								
, P.O. Box 683 ires that the death certiff signed by the attending be detached for use as it	by Pi	Part II. Other significant cond	itions contributing	to death but not re	esulting in the	underlying o	ause gi	ven in Par	t I.				_	ne cause of death?
S, P irres th signe d be d	1 73		··											bly 4 Unknown
ords v requ s been should	je t										opsy	pri	or to co	opsy findings available impletion of cause of
He land are had age 2	Completed										formed?		ath? ✓ Yes	2 No
al R an: T ertific etor. p	e C	25. Was case referred to medic				26		of Death (	Check on	ly one)				
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it as after death.  **A Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	8 2	examiner?  1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Dutpatien					Home 5		ce 6 🗸		Scene
J of V Jing Phy After tl funeral	٦	27. Manner of Death  1 Natural 5 Re	-0(M8)	e of Injury th, Day,Year) D:	28b. Time of FOUND:	Injury 28		y at Work?	IS	8d Describ ubject sh		y occurre	d	
ivisior or Attend after death Director:	äţi		estigation Jan 21	, 2007	2200 hrs			es 2 🗸		56.1				
Division pital or Attent ours after death neral Director: filled in by the	Certification:		uld not be	ace of Injury - At he		et, factory, o	office bu	uilding, etc		or Town	State)			al Route Number, City
ospita hours nueral y fille		29a. Certifier	Physician: To the b	Single Fan		irrad at the t	ime de	to and sic		7 Yankee I		_ <u>-</u> -		d.
Division To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only Certifying	eminer: On the basi and manner	s of examination a	ge, death occu nd/or investiga	ation, in my	ppinion,	death occ	ce, and di curred at t	he time, da	te and plac	e, and du	e to the	cause(s)
F. ½ F. Ø	Me	29b. Signature and title of certi	fier	Stated		29c.	License	number			29d. D	ate signe	d (Mon	th, Day, Year)
		hig an	i, mo				O.C.N	M.E.			Janu	ary 22,	2007	
		30. Name and address of person						40.046	0.4					
4-20+1			tant Medical Ex			et, Baltin	ore, I	MD 2120	U1					
	27.17.	31 Date filed (Month, Day, Yea	r) 32.	Registrar's Signati	лe .∦	2								

Registrar

		1	For State Registrar	State of Maryland			t of He e of D		d Men		iene <sub>eg. No.</sub> 20	07	03179
9 10	Physicia		1. Decedent's Name (First, Middle, Last Marjorie Kersey							Date of Deat Month Inuar		2ඊშ7	3. Time of Death 4:45 P M
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)				ocation of De	eath		4c. County		- 3 - 1
	Funeral	*	Annapolis Assis 5. Social Security Number 6. Se	7. Age (In yrs. li				If Under 24 H	Ain. (	Date of Birth Month, Day,	Year)	9. Birthp Cour	lace (State or Foreign
24.	Director	-	213-16-4784  Usual Residence of Decedent  10a, State 10b, County	0.	, Town or Lo	ocation			De	24	1924		Od. Inside City Limits
	a-f sho	cto	Maryland Anne Ar		napo1	_							Y☐Yes 2☐No
	or 28	Dire	10e. Street and Number			10f. Zip		^		1	og. Citizen of US A		ntry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelih and Mental Hygiene. It heelih and Mental Hygiene item 27 is marked other than "natureli, or items 23a or 28a-f show other traumatic event, the Madical Examinar must be multiled at	by Funeral Directo	940 Bay Forest  11. Marital Status  1 Never Married 2 Married  3 November 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1  Yes 2 No If Yes, Give X Year or Dates:	S. 13.			Danic Origin? Mexican, Pi Specify:	? (Specify uerto Rica	Yes or No- n, etc.)	14. Rac	ce - Americ ck, White,	
	within 72 hour ene. then "nature! the Medical E.	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ication	(Give life.	NOT U	se retired)	ring most of	working		16b. Kind of B	d Sta	ates
121	e filed within al Hygiene. i other then '		12th  17. Father's Name (First, Middle, Last)	0	Po	stal	C1e		Name (Fir		Posta Maiden Sumai		rvice
Maryland	2 should be f and Mental h is marked of surmatic eve	To Be	Samuel Wells			`					hnson		
/Jan	2 sho	4	19a. Informant's Name/Relationship (7		100			d Number o. .gton			r, City or Town apoli		
di	1 and 2 Heelth tem 27 i		Avis Kersey(Dav 20a. Method of Disposition		lace of Disp			_	Date		20c. Location		
E E	Pages ent of nt: If it		1 Burial 2 Cremation 3 ☐ 4 Donation 5 Other (Specify	Memovar from State	moria				-19-	07	Annap	olis	, Md.
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot ance.		21. Signature of Funeral Service Licen	See MOS48	3 8	¥m\ame F 321 V	reest Vest	of &ciliso St. 1	ons l Anna	Mortu polis	aary, s, Md.	P.A. 214	01
	3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	h. Do not en	nter the mo	de ol dying	such as car	rdiac or re	spiratory ari	rest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a									
8760,	ate be executed shysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  C.  Due to (or as a conseq									
O. Box 6	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome of pregnation to the control of the control o	death 3	□Ectopic p						ate of delivionth	very Day Year
rds, P.	quires that n signed to ald be delt	b	Part II. Other significant conditions of				cause give	n in Part I.	_		obacco use con res 2 Ano	3 Pro	the cause of death?
Records,	rhe law requir le has been si age 2 should	Completed	ANEMIA						-			. Were aut prior to co death?	copsy findings available ompletion of cause of 2 \sum No
Vital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of	,	heck only o	one)	AS	SIJTED.
of	ng Phys fter this uneral di	ion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time Injury	of	28c. Injury Work	4 🗀 110131	28d		dence 6 200		IN LIVING
Division	or Attendition distribution of Attended Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, larm, s fy)		ry, office		281.	Location (S City or Tox	Street and Num wn, State)	nber or Ru	ral Route Number,
_	Hospital 24 hours a Funeral I	edical C	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best of my kniner: On the basis of examination and manner stated.	owledge, dea ation and/or	ath occurre investigation	d at the tim on, in my op	e, date and i inion, death	place, and occurred	I due to the at the time,	cause(s) and n date and place	nanner as a, and due	stated. to the cause(s)
	ro the vithin 2	Med	29b. Signature and title of certifier	1		2	9c. License				29d. Date sign		
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	1		30. Name and address of person tho	completed cause of death (Ite	m 23a) (Typi	e, Print) Hwy	, Su	ille à	204,	nil	Hersvi	Ue	MD 2112
		ate trar	31. Date liled (Month, Day, Year)	32. Registrar's Sign		Line	6)		-				

			For	State of Mar	yland / [	Departme	nt of H	ealth and	d Mental Hy	giene	7 00100
			For State Registrar			Certifica	te of L	Death		Reg. No. C U U	/ U3 8U
	Physicia	an	1. Decedent's Name (First, Middle, Last)	1		Ki	<b>^ a</b>		2. Date of De.	Day 700	3. Time of Death
a side	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	10	4b. City	, Town, or	Location of De		4c. County of D	path
			Chester Kiver	Hospita	a) (e)	He C	r 1 Year	If Under 24 F	Irs. 8. Date of Bird	Ken	Birthplace (State or Foreign
į,	Funeral Director		5. Social Security Number 6. Security 136–38–1230	M 25 F	(In yrs. last bir 59	Yrs. Months			in. (Month, Da	y, Year)	centon, NJ
	2		Usual Residence of Decedent  10a. State 10b. County		I Oc. City, Tow	n or Location					10d. Inside City Limits
	Maryla f shor	ŗo	Maryland Ken		Lynch						1 ☐ Yes 2 <b>7€7</b> 0
	I within 72 hours after death with the Maryland liene. The "naturel", or Iteme 23e or 28e-f show the Medical Examiner must be notified at	Director	10e. Street and Number			10f. Z	ip Code			10g. Citizen of What	
	eath w		11595 Lynch Roa	12. Was Decedent Ev	rer in U.S.	13. Was Dec	2167		(Specify Yes or No	U.S.F	merican Indian,
9	after d	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces?  1 Yes 2000		If Yes, sp	ecify Cubai	Specify:	ierto Rican, etc.)	Black, W Specify:	hite, etc. White
21215-0036	hours urel',	d by	3 ☑ Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	163	Decedent's He	ual Casuna	tion		16b. Kind of Busine	
215-	c 2 3	Completed	(Specify only highest grad  Elementary/Secondary (0-12)	e completed) College (1-4or 5+		(Give kind of w life. DO NOT	ork done d use retired,	uring most of	working	700.112.0	,
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aryl	2 should be and Menta is marked aumatic ex	ဥ	19a. Informant's Name/Relationship (T)		1	-				er, City or Town, State	
	s 1 and 2 should t Health and Mer Item 27 Is marke other traumatic		Chanin King/Dau  20a. Method of Disposition	ghter		$595~{ m L}_{ m S}$ f Disposition (N		Road,	Lynch,	MD 21678	
nor	0 0		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	Capit	ry, crematory or col Cre	other place emato	ry 01	/22/2007		
Baltimore,	artin orts Inju		21. Signature of Funeral Service Licens		Scrvi	Ce Name	and Addres	s of Facility	÷	JNERAL HO	
8	Dep fime any		Pray	is Corr	TILESTA	212 N	Dro	-A C+	Middloto	TATO DE 10	9709 Approximate
			23a. Part1. Enter the disease, or somp shock, or heart failure. List ediy o Immediate Cause (Final	ne cause on each line	. I Da	11 (1 0		home-	ulac or respiratory a	rrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	consequence	~ /-	ymy,	MI THE			27 months
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 23 2	consequence	01).					
,00	te be executed ysicien and ne burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence	of):					
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Box (	leath certificat attending phy i for use as thi	In/Me	23b. was decedent pregnant	23c. If yes, outcome o		n 3⊡Ectopic	oregnancy			23d. Date of	
O. B	The law requires thet the death certifica tie has been signed by the attending phoage 2 should be detached for use as if	Physician/Med	in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	4☐Pregnant at ti 9☐Unknown		5 ☐ Other (				Month	Day Year
Δ.	thet the de ned by the a detached f		Part II. Dther significant conditions co	ntributing to death but	not resulting	in the underlying	cause give	en in Part I.	23e. Did t	obacco use contribut	e to the cause of death?
rds	w requires been sign should be	ed by							_ 1×	Yes 2□No 3□	Probably 4 Unknown
Records,	s law requ	Completed							24a. Was	an 24b. Were prior death	a autopsy findings available to completion of cause of
Vital F	in: The	e Cor	25. Was case referred to medical					26 Place of	1 ☐ Yes  Death (Check only	20 10	
f Vii	Physician: this certific ral director,	To Be	eyaminer?	Hospital: 1 Inpatien	t 2 ER/O	utpatient 3 1	Och Oth	0.00		dence 6 Other (S	Specify)
on of	ling Pt I. After th 'uneral		27. Magner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury M	28c. Injun Work	/ at k? Yes 2 □ No	28d. Describe	how injury occurred	
Division	Attending or death.	flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injul	ry - At home, f			163 2 110	28f. Location (	Street and Number of	r Rural Route Number,
Ö	ital or irs afte rai Dir led in l	Cert	4 Homicide	building, etc.							
	To the Hoepital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examination a	e, death occurre nd/or investigati	ed at the time on, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within To the Compli	₹ E	29b. Signature and title of certifier	1 -	)	2	9c. License	e number	21	29d. Date signed (M	onth, Day, Year)
•	,		Jan 4	y can	,		Mel-	ソロ	000	1 22/	07
6	0	10	30. Name and address of person who of Susan K Ross	ompleted cause of de	ath (Item 23a)	(Type, Print)	Arc	Ch	Anton n	1 221	2
1	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1 677	1			······································	
	Regist	rar	JAN 2	3 2007	Milya	B. A	med.	/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007 January 20, 2:45 AM Kieh1 Frances Maurine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City 2957 Hearthstone Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1924 Davs 1 □ M 2 F Hours California 525-36-3645 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show a notified at 10a State 10h County 1 ☐ Yes 2√ No Director AZMaricopa Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or dical Examiner must be r death with 85013 USA 6049 N. 9th Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Armed Forces
1 ☐ Yes 2X☐
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married 1□ Yes X No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the Real Estate Agent Ith and Mental Hygie

27 is marked other

traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental Health and Mental Health and Mental Health Charles Goodloe Lena Tinslev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a tem 27 is 2957 Hearthstone Rd. Ellicott City, MD 21042 Mark Kiehl/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition \$ = 6 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of important: If any injury or once, 01/23/07 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Light Goling Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Cell Carcinon SI Immediate Cause (Final disease or condition resulting in death) ramous **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine physician and sthe burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed certificate has irector, page 2 1□ Yes 2□No or Attending Physician; 25. Was case referred to medical examiner? director, To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2√ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation injury 1 ☐ Yes 2 ☐ No after death.

I Director: A in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

(Check only one)

29b. Signature and title of certifier

an HD 31. Date filed (Month, Day, Year) **JAN 23** 2007

leted cause of death (Item 23a) (Type, Print)

Lark Brown PD Elkridge MO 21075

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 11F1#24a, per VERB., #25, per HIS., 604, 2/5/07, NS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yeer **Physician** 10:27 am 2007 DOROTHY J. LITTLE /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7/10/1946 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 XF Yrs. 60 220-42-9307 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or iteme 23s or 28s-f show 1 Yes 2 No MD Harford Whiteford Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1225 Old Pylesville Road 21160 United States Funeral 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within innent of Health and Mental Hygiene. Int: If item 27 Ie marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Newspaper Pre-Press Technician 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Evelyn Folker James Cantler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 le eny injury or other tra: once. 1225 Old Pylesville Road, Whiteford, Md 21160 Lee Little/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 remation 3 ☐ Removal from State 2/2/2007 Leola, PA Evans Eagle Cremat. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Line see 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, Pa 17314 23a 11. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In ediate Cause (Final dease or condition resulting in death) when my occurred interestion **Physician** 30 --/Medical Due to (or as a consequence of): Examiner رسده ( range encols rossible Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner nding physicien end use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy etter for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) \_ 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be were tril petrolones, hypertesies 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death [Check only one] Be examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2500 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide or A To the Hospital of within 24 hours of To the Funeral D completely filled in TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 060444 1/17/07 ري-20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave., Ste. 420 Bel Air, mo 21014 ey, m. O 4C North hanani

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) [ EB 0 5 2007

marke

32. Registrar's Signature

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				Maryland / I	•			Mental I	-lygie	ne		
Ę			1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate	OT D	eath	2. Date o	Reg.	No. 2	107	3. Time of Death
Phy	ysicia	an	SHIRLEY LIDKE					Month		Day 7	Year 2007	1:18 PM
	/ledic amin		4a. Facility Name (If not institution, give street and num	nber)	4b. City, To	own, or L	ocation of Death	<u> </u>			y of Death	1.18
6. 6.			UNIVERSITY OF MARYLAND MEDIC	AL CENTER	BA	ITin	nore					
Fun	eral			7. Age (In yrs. last bi	rthday) If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of (Month	Birth Day, Ye.	ar)	9. Birthpla	ace (State or Foreign
Dire	ctor	-	213-42-4154 Usual Residence of Decedent	62	Yrs.			Feb.	8, 1	944	Maryl	and
yland	të d		10a. State 10b. County	10c. City, Tow	n or Location						10	d. Inside City Limits
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ith th	ou ac	Directo	10e. Street and Number		10f, Zip C	Code			10g.	Citizen of	What Count	ry?
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fter de r item	lner	Funeral	1 Never Married 2 Married 1 Yes	rce <i>s?</i> 2 <b>☑</b> No	13. Was Decede If Yes, specif		, Mexican, Puerto	o Rican, etc.	)		ack, White, e	tc.
hours af	Ехап	۵	3 ☐ Widowed 4 ☑ Divorced If Yes, Giv Year or Da	e ites:	1 ☐ Yes 2	<b>N</b> o	Specify:			Speci	ity: Whi	te
<b>3-0</b>	dioal	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual (Give kind of work	done du		king	16b	. Kind of E	Business/Indi	ustry
within ene.	e Me	dm	Elementary/Secondary (0-12) College (1		life. DO NOT use	,					l. 0-1-	
filed Hygi	ent,	ပိ	17. Father's Name (First, Middle, Last)	i N	urses Aid	$\overline{}$	18. Mother's Nam	ne (First, Mid			<u>h Care</u>	
ary iditio Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show	tic ev	To Be	Noah Overbay				Elsie I	rono l	Simo	nal (	Oue the	,,
DaltIIIIOre, Interview A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show	anma		19a. Informant's Name/Relationship (Type. Print)	198	o. Mailing Address (							
and 2	er tra		Rev. Anthony Lidke (Son)	3	14 Allian	ce S						
ges 1 t of H	or ot		20a. Method of Disposition  1 ☐ Burial 2 【■ Cremation 3 ☐ Removal from 5	comoto	of Disposition (Name ery, crematory or oth	e of ner place,	)	Date	20c	. Location	- City or Tov	vn, State
altimor mit. Pages partment of portant: If II	Jury		4 □ Donation 5 □ Other (Specify)	R.A.	Ferris &	Co.	2/1/	2007	We	st Cl	hester	, PA
Depa Depa Impo	any Ir		21. Signature of Funeral Service Licenses	I	22. Name and	Address	of Facility Mi	tchell	-Smi	th Fo	uneral	Home, P.A
196			23a. Part1. Enter the disease, or complications that ca	aused the death. Do						ae 6)		MD 21078 Approximate
Physic	ian		shock, or heart failure. List only one cause on ex Immediate Cause (Final	ach line. 4D STAGE	0 1156	Tuli	1151207	FR. I	111-			Iriterval Between Onset and Death
/Med	ical		disease or condition resulting in death)  a	or as a consequence	of):	1102	HCHICI	17111	4766			
Exami	ner		Sequentially list conditions.	EPSIS								
pe pe	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence	of):							
executed n and	al-trar	xan	that initiated events	or as a consequence	of):							
	e buri		<b>L</b> <sub>d</sub>									
The law requires that the death certificate be to have been signed by the attending physicia	as the	Physician/Medical										
ath cer	r use	an/N	23b. Was decedent pregnant	come pf pregnancy irth 2 D Fetal deat	h 3 ⊟Ectopic pre	anancv					ate of deliver	,
e deat	bed fo	sici	in the past 12 months?  1 □ Yes 2 □ No 4 □ Pregn 9 □ Unknown 9 □ Unknown	ant at time of death	5 ☐ Other (spe				_	l M	ionth I	Day Year
that th	detacl		Part II. Other significant conditions contributing to de	eath but not resulting	in the underlying cau	use giver	n in Part I.	23e. [	Did tobaco	co use cor	ntribute to the	e cause of death?
ecords, law requires as been signe	ld be	d by							☐ Yes	2 □ No	3 ☐ Proba	ably 4 (Multiple)
w red	shou	lete						24a. \	Vas an	24b	Were auton	sy findings available
The la te has	age 2	Completed						F	utopsy	l?	prior to com death?	pletion of cause of
VII.all Iclan: T Sertificat	ctor, p	BeC	25. Was case referred to medical examiner?		-		26. Place of Dea	th (Check o		INO	1 ☐ Yes	2 □ No
Physic rthis ce	Il dire	70	1 Yes 2 No Hospital: 1 1 1		utpatient 3 □ DOA		4 LINUTSING H	ome 5□F	Residence	6 🗆 01	ther (Specify,	)
Attending Physician: In death.	funera	ion:	TENTALITIES OF CHANGE			c. Injury Work?		28d. Descr	ibe how in	njury occu	irred	
VISION Attending ar death. rector: Afte	y the	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e, Place	of injury - At home, fa	arm. street. factory.		es 2□No	28f Locatio	on (Street	and Num	her or Rural	Route Number,
after after	d in b	Certification:	4 Homicide determined building	ng, etc. (Specify)				City of	Town, Si	tate)	iber of Hurar	Houle Hullioel,
UNISION OF VITAL MEDIANAL TO THE HOSPITAL OF ATTENDED TO THE PROPERTY OF THE PURPORT OF THE PURP	iy fille		29a. Certifier (Check only 2 Medical Examiner: On the base)	best of my knowledg	e, death occurred a	t the time	e, date and place	, and due to	the cause	e(s) and n	nanner as sta	ated.
the H nin 24 the F	прlete	Medical	and manr	ner stated.				irred at the t				
or ¥¥°C	8	2	29b. Signature and title of certifier		290.	License	number		29d.	Date sign	ed (Month, E	
,			20 Name and address of passes its	MD of doath (the soc)	(Turno Drint)	12	1181			12	7/200	)
6			30. Name and address of person who completed caus Robin Enck 225. GREEN,	·	Bialt, mo	0 1=	MO	2121	5 (			
	Sta	te	31. Date filed (Month, Day, Year) 32.	gistrar's Signature		, CC	1 171.)					
Re	gistr	ar	FEB 0 5 2007	wa !	Roselle							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:45 AM 0(15 Irene 30 2007 Tanyary /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner lase 1/1/10s porta 1Staux washington 8. Date of Birth (Month, Day, Year) Nov. 21, 1932 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2X F 74 Maryland 220-28-7790 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Hagerstown MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number natural", or Items 23a or U.S.A. 21740 14038 Cedarfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Retail permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If Item 27 Is marked other than any injury or other traumatic event, the Catalog Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman Freyman Logue Mary Grace Rupp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alva E. Long/Husband 14038 Cedarfield Road, Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/1/2007 Hagerstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel S. Mark Su 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 Ominute **Physician** Due to (or a consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Due to (or as a consequence of): and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) □Yes ate has been signed by the page 2 should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes \$12 No 1 🔲 Inpatient 2 DOA 3 DOA ၉ this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Natural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tast 32 eqistrar's Signature 31. Date filed (Month, Day, Year) State FEB 05 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	rtificate of L		Memairry	Reg. No.	2007	03185
Adak Pa	Dhuaisic	_	1. Decedent's Name (First, Middle, La	st)				2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		ROSE K.	LEVIN				JANUARY			
<b>)</b>	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or		ıth	4c. C	County of Death	
		è	HOLY CROSS NURS:				NSVILLE If Under 24 Hr	s. 8. Date of Bi	irth	MONTGOME	ERY  pplace (State or Foreign
	Funeral Director		150-09-5500	ex 7. Age	(In yrs. last birthday) 95	Months Days	Hours Mir		ay, Year)	Cot	JERSEY
	land bw <u>t</u>	H	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary -f sho fied a	ţ	MARYLAND MONTGOI	ÆRY	В	URTONSVILLE					1 ☐ Yes 2 🖾 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
	3a o		3415 GREENCAST	LE ROAD		20	0866			U.S.A	Α.
	ms 2	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (	Specify Yes or Nerto Rican, etc.)	lo- 1	<ol> <li>Race - Amer</li> <li>Black, White</li> </ol>	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at angoing.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		,		Specify:	WHITE
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7	within lene. than " the Mec	dm	Elementary/Secondary (0-12)	College (1-4or 5	+)	BOOKKEEPE				HOTEL	
	filed v Hygie other 1	ပ္သ	17. Father's Name (First, Middle, Las	)		Doorden		ame (First, Middl	e, Maiden S		
ā	d be ental ced o	To Be	DAVID KAHN				S	OPHIE UNK	NOWN		
Maryland	should and Men marke	Ĕ	19a. Informant's Name/Relationship	Type. Print)	19b. Mail	ing Address (Street a	and Number or	Rural Route Num	ber, City or	r Town, State, Z	Zip Code)
<i>∞</i>	and 2 salth ar		GEORGE LEVIN - SON		418	7 LORD CULPI	EPER LANE	, FAIRFAX,	VIRGI	NIA 22030	0
<u>၈</u>	s 1 al f Hea item othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	e)	Date	20c. Loc	cation - City or	Town, State
E E	Pages nent of ant: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			ON CEMETERY	1	8/2007	ADEL	PHI, MAR	YLAND
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service Lice	Rudewa	H	22. Name and Addres IINES-RINALD: .1800 NEW HAI	I FUNERAL	HOME, INC	VER SP	RING, MA	RYLAND 20904
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10	Physician		Immediate Cause (Final disease or condition	a ASCVD						-	Onset and Death YEARS
1	/Medical		resulting in death)	a	a consequence of):						
'A	Examiner		Sequentially list conditions.	D	TO THRIVE						1 YEAR
	pe tis	ine	Sequentially list conditions, if any, leading to immediate output Entire Underlying Cause (Disease or injury	Due to (or as	a consequence of):					-	
	ecute and I-trans	Examine	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
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189		ledical				- Salin					-
.O. Box	law requires that the death certifias been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		. 2	23d. Date of del Month	livery Day Year
Ω.	that the by detac		Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did	d tobacco u	se contribute to	the cause of death?
ds	uires 1 signe 1d be	d by						_ 1[	Yes 2	X No 3 □ P	robably 4 □Unknown
or Vital Records,	Ф <del>г</del> Ф	Completed				, ., .		24a. Wa au pe	topsy rformed?	prior to death?	utopsy findings available completion of cause of
<u>_</u>	ician: The certificate harector, page		25. Was case referred to medical				16 Place of F	1□ Yes Death Check onl		1∐Yes	s 2□No
Ħ	Physician: this certificatal director,	Be C	examiner?  1 Yes 2 X No	Hospital:	ent 2 ER/Outpati	ent 3 DOA Oth	000	Home 5□Re		6 ∏Other (So	ocify)
		 7	27. Manner of Death	28a. Date of Inju	ıry 28b. Time	of 28c. Injur		28d. Describ			icity)
O	nding Pl th. : After the funeral	tior	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury		Yes 2 □ No				
Division	I or Attending after death. Director: After In by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, s c. <i>(Specify)</i>	street, factory, office		28f. Location City or 7	(Street an Town, State	d Number or R	ural Route Number,
_	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledical Ce	29a. Certifier 1 💢 Certifying R (Check only 2 Medical Ex-	Physician: To the best aminer: On the basis of and manners	of examination and/or	ath occurred at the ti investigation, in my	me, date and pl opinion, death o	ace, and due to the courred at the time	he cause(s) ne, date and	) and manner a d place, and du	s stated. e to the cause(s)
	Fo the Within To the	Me	29b. Signature and title of certifier	_		29c. Licens	se number		29d. Dat	te signed (Mon	th, Day, Year)
	3		<b>•</b>			D37	573		JAN	NUARY 17,	2007
•			30. Name and address of person wh				EISTERSTO	OWN, MARYL	AND 211	L36	
	St	ate	31. Date filed (Month, Day, Year)	32. Pist	rar's Signature						
	Regist	rar	JAN 22	2007	IN TO	STORE STORES					

			Please	Type or Prin							_egible.	
		For		State of Ma	arylan		artment of H		Mental Hy	/giene	0007	00106
		1 - State Registrar				Cei	rtificate of	Death		Reg. No.	2001	03:00
Physici	an	1. Decedent's Name	A. Litwa	st)					2. Date of D Month	Day		3. Time of Death
/Media		-		e street and number)			4b. City, Town, o	r Location of Dea	01	21	2007 County of Dea	th 6 A "
Examir	ier	,	_	Hospital			Berlin	. socialist of Boo		10.1	Worces	
Funeral		5. Social Security No	umber 6. S	ex 7. Ag		last birthday)	If Under 1 Year Months Days	If Under 24 Hr		irth		thplace (State or Foreign ountry)
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land		Usual Residence of 10a. State	10b. County	***	10c. City	y, Town or Lo	ocation					10d. Inside City Limits
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th the or 28a or proti	Director	10e. Street and Num			110		10f. Zip Code			10g. Citiz	en of What Co	ountry?
ath will	ral	830 Litw	a Lane				19014			US	SA	
er deg Items	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or N erto Rican, etc.)	0- 1	4. Race - Ame Black, Whit	
rs after	by F	1 ☐ Never Marrie 3 ☐ Widowed	_	1 ☐ Yes 2 ██ If Yes, Give Year or Dates:	NO		1 □ Yes XXNo	Specify:			Specify: Wh	ite
If I I I I I I I I I I I I I I I I I I	ted	/0	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	pation		16b. Kir	nd of Business	
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led wi	Cou	12				Ho	memaker	40.14.11.1.11.11	(F)		Home	
I be fill he ded out	Be	17. Father's Name (		,					ame (First, Middle		Surname)	
ine, intally lating ZIZIOOOOO s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	은	Frank W	<del>-</del>	Type, Print)		19b. Mailir	ng Address (Street		Poremski		Town State	Zin Code)
nd 2 salth ar			Davidsor				Litwa La				rom, otato, i	<b>p</b> 0000)
ss 1 a of Hez		20a. Method of Disp			20b. P	Place of Dispo	osition (Name of matory or other place	ce)	Date		cation - City or	Town, State
Page nent annt: If			□ Cremation 3 □ 5 □ Other (Specify	Removal from State y)		vn Cro	ft Cemete	ry 1/26		Lin	wood,	PA
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than any hijury or other traumatic event, the Magnee.		21. Signature of Fu	neral Service Licer	isee			2. Name and Addre			age F	uneral	Home
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		shock, or hear	rt lanure. List only	plications that caused one cause on each in	the real	n. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	n al	a. Due to (or as	1500	/ D	··					EVERAL YES
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death certificate be sattending physicial for use as the burn	Physician/Medical		•	_d								
n certii nding use a	n/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome						2	3d. Date of de	liverv
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has the law	Completed		-							s an opsy formed?	24b. Were at prior to death?	utopsy findings available completion of cause of
n: The ficate or, pag		25. Was case referr	red to medical						1□ Yes	2DFNo	1 ☐ Yes	2 □ No
Physician: The Is Physician: The Is or this certificate har	o Be	examiner?		Hospital: 1 ☐ Inpatie	nt 25%	ER/Outpatier	nt 3 DOA Oth		eath (Check only Home 5 ☐ Res		Other (See	noifie)
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endir sath. or: Af	Certification:	1 Natural 2  Accident	5 Pending investigation	1				Yes 2 □ No				
or Att fter de Direct in by t	rtific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injubuilding, etc	ury - At ho c. <i>(Specif</i> y	ome, farm, str	eet, factory, office		28f. Location City or To	(Street and own, State)	Number or R	ural Route Number,
pital ours a eral [		29a. Certifier	1□ Certifying Ph	yslcian: To the best of	of my kno	wledge death	h occurred at the ti	mo, date and plac	and due to the	2 221122 (2)	and manner :	
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only one)	2 Medical Exam	niner: On the basis of and manner sta	f examina ited.	tion and/or in	vestigation, in my o	ppinion, death oc	curred at the time	, date and	place, and due	e to the cause(s)
To th withir To th comp	Me	29b. Signature and		-/:	·		29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
		Dono	Thy C.	Holywatt,	M.L	12		0624	/_	01	-23-0	27
BA 15		~	es of person who	completed cause of de	eath (Item	23a) (Type,	Print)	-23				
	ot o	31. Date filed (Mont	th, Day, Year)	32. Registro	ar's Signa	ture 14	· D 2	203 SN	BUN ST.	SNOW	Hue,	My 21863
Sta Registi			IAN 2 3 2	nn7 /	AZ J	K A	sarle					

		-	For State Registrar	State o	f Marylan		artment <i>tificate</i>			and M		giene Reg. No.	007	0318	37
H	Physicia	an	Decedent's Name (First, Middle, CATHE)		MURPHY						2. Date of Dea Month JANUARY	Day	Yea	3. Time of Do	
	/Medic Examin	_	4a. Facility Name (If not institution,				4b. City, T	own, or	Location o	of Death	UANUART	1	County of De	8:20	A
			WILLIAMSPORT N						LLIAN					NGTON	
	Funeral Director		5. Social Security Number 190-12-7979	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 9	last birthday) 5 Yrs.	If Under 1 Months	Days Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt	, <sup>7</sup> 191	9. B	inthplace (State or F ST VIRGINIA	Foreign ∖
-	o		Usual Residence of Decedent												
	Aarylau f ahov	ō	MD WASH	INGTON	10c. Cit	y, Town or Lo WILL	IAMSP	ORT						10d. Inside City	
	r 28a-	irect	10e. Street and Number				10f. Zip (		<del>-</del>			10g. Citiz	en of What	Country?	
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Maryland 21215-0036	75 C O A	Be	17. Father's Name (First, Middle, L CHARLES THURMA								(First, Middle,		Sumame)		
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L,			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on e	each line.		er the mode	of drying	, such as	cardiac o	r respiratory ai	rrest,		Approximate Interval Betwee Onset and De	ath
	hysician /Medical		disease or condition resulting in death)		O SETS									48 Hou	E7
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Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pre	anancv				2	3d. Date of		
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<u>&gt;</u>	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2 🗶 No			ER/Outpatier		A Othe	<sup>IC</sup> 4 <b>⊠</b> Nu	ırsing Hor	me 5∐Resid	dence 6	□Other (S	oecify)	
000	ding h. After funer	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investig		of Injury th, Day Year)	28b. Time o Injury	f   28	C. Injury Work	at ? fes 2 □ l		28d. Describe I	how injury	occurred		
Division of Vital Records,	r Attandi er death. rector: A by the fu	Certification;	3 Suicide 6 Could r	ot be 28e. Place	e of Injury - At h	ome, farm, sti	eet, factory,				28f. Location (S	Street and	d Number or	Rural Route Numbe	er,
۵	Hospital or 14 hours after Funeral Directely filled in t		29a. Certifier ★ Certifyin							4 - 1					
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	(Check only one)	g Physician: To the Examiner: On the b and man	easis of examination stated.	ation and/or in	n occurred a vestigation,	in my op	e, date an inion, dea	ith occurr	and due to the ed at the time,	date and	and manner place, and c	as stated. lue to the cause(s)	
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	6-		30. Name and address of person	K MD	sa of death fli-	m 23a\ /Ta-		25	5700	$\cup$		JAN	MARY	27,20	007
22-	6		Ted Howe 15	JA. N. P.	MASITS	ST.	Will	IAN	ላሩምታ	R7.	MD	7	1799	5	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 2	32. F	Registrar's Sign	ature 34							•		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year lahoner Juanita 8:42 Jac 2007 28 /Medical 4b. City Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Maryland saltimore Medical Center Iniversity of Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours Director 577-44-6660 Jan.15,1933 Wash. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Machinal Control of the Contr 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3411 21st Street, 20020 SE United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☑ No Yes, Give Baitimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced Specify. Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Domestic</u> <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Martha Parker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3411 21st St., Washington, DC SE 20020 Beverly H. Pope/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 2/2/07 Clinton, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. P. nt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** De 0515 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Intravascular 1 Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760. Records, P.O. Division or Vital To the Hospital or Attending within 24 hours after To the Funeral Dire

3

State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

and manner stated

54 Baltimore

29d. Date signed (Month. Dav. Year)

MD 21201

_		1 - For State Registrar	State of M	larylan		artment rtificate			and Me		jiene	007	03189
4 5	2	1. Decedent's Name (First, Middle	le, Last)		-				1	2. Date of Dea Month		Vear	3. Time of Death
Physici /Medi		Abraham Ja	mes Martin						i	January	28',	2007	5:15 P.M
Examir		4a. Facility Name (If not institution	n, give street and number	)		4b. City, To	own, or l	ocation o	f Death		4c. Cc	unty of Death	
		22726 Cavetow	n Church Rd	•				thsbu			1	<i>lashing</i>	ton
Funeral Director		5. Social Security Number 220 – 10 – 3479	6. Sex 7. A 1 ☑ M 2 □ F	ge (In yrs. 85	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day arch28	, 1921	9. Birthi Coul Mary	place (State or Foreign ntry) Jiand
and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Aaryli Febo	٥		ashington			ithsbu	urg						1 ☐ Yes 2 🛣 No
the A	ect	10e, Street and Number		1		10f. Zip C	Code				Og. Citizer	of What Cou	ntrv?
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ne 2	era	11. Marital Status	12. Was Deceden		.S. 13.	Was Decede	nt of His	panic Orig	gin? (Spec	ify Yes or No- ican, etc.)	14.	Race - America	can Indian,
r lie	교	1 Never Married 2 Mar	ried Armed Forces	No.					, Puerto H	ican, etc.)	1	Black, White,	etc. nite
ours a	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	44-4	5	1 □ Yes 2	ALI NO	Specify:			St	ecify: WI	
21215-0036  So within 72 hours after death with the Maryland gjene. et than "naturel", or lieme 23e or 28a-f show in the Wedleal Examiner neut the mytified at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupat done du	ion iring most	of working	9	16b. Kind	of Business/In	dustry
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Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It is marked other than "naturel", or Iteme 23e or 28a-1 show traumatic event, the Wedlest Examine must be notified as	Be	Paul Henry						18. Mother		l Marie			
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Man d 2 s th an traur		Joann Willard								Smithsl			
Te, No. 1 and Health Health tem 27 other tr		20a. Method of Disposition			Place of Dispo	sition (Name	e of	- 1	Da	-		tion - City or To	
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Itin		21. Signature of Funeral Service		_   Cr	nurch C	. Name and	-	of Facility	2007				
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Box 68 leath certificat attending phy for use as th	Mec	IF FEMALE:					-	-					
30) ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pre					230	<ol> <li>Date of deliver</li> <li>Month</li> </ol>	ery Day Year
P.O. BOX ist the death cer dby the attendin etached for use	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a	at time of d	eath 5	Other (spec	cify)						,
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D Phy g Phy er this	Ë	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		c. Injury			d. Describe h			<b>y</b> )
oding Ath. e fun	atio	1 Natural 5 Pendi 2 Accident invest	ng (Month, D igation	ay rear)	Injury	М		/ es 2 □ N	No				
VIS Atte	illic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place of It	njury - At h	ome, farm, st	eet, factory,	office		28	3f. Location (S City or Tow		lumber or Rura	al Route Number,
S affe	Certification:	4 1101110100	building, e	iic. ( <i>396cii</i>	y)					City of TOW	ii, State)		
Division of  To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	t of my kno	wiedge, deat	h occurred at	t the time	a, date and	d place, ar	nd due to the c	ause(s) an	d manner as s	stated.
the hin 2, the land	Med	one)	and manner s	stated.			License						
Vit To Cor	-	29b. Signature and title of certific								-		igned (Month,	⊌ay, rodi/
7			drm				189	17/		- 4	1/4	1107	
5		30. Name and address of person William B. Ker.					Sm	ithel	bura.	Md. 21	783		
THE PERSON NAMED	ate	31. Date filed (Month. Day, Year	Regis	trar's Sign	wire				3 /		_		
Regist		31. Date filed (Month, Day, Year FEB 0 2	2007	ט ל	and the	refer 1							

			1 - For State Registrar	State of	Marylan		artment o				ene g. No. 0	)7	03	90
	g/f		1. Decedent's Name (First, Middle, La	ist)						Date of Death Month	Day	Year	3. Time o	of Death
	Physici /Medio		J. Douglas McL	aren						January		007	7:45	рм
	Examir	er	4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City, Tow	m, or Location	of Death		4c. County	of Death		
		2	Montgomery Gener  5. Social Security Number 6.		tal . Age (In yrs.	last highday)	If Under 1 Y	Olney ear If Under	24 Hrs lo	Date of Birth	M	ontgo		or Foreign
16. 10.	Funeral Director			1 <b>½</b> M 2□F	75	Yrs.		ays Hours	Min.	(Month, Day, ec. 22,			olace (State otry) v York	
	death with the Maryland ms 23a or 28a-f ehow rmat be notified at		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	Od. Inside C	City Limits
	B-1 et	ctor	New York Suffol	k	Ce	nterea	ch						1 🗌 Yes	2 No
	or 28	Olre	10e. Street and Number				10f. Zip Cod	de		10	g. Citizen of V	Vhat Coun	itry?	
	ath wi	ral	129 Fawn Lane E	ast				11720				SA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Evantral retrieval to Inditied 81 once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	es? ! 🗌 No		Was Decedent If Yes, specify ( 1☐ Yes 2 <b>%</b> C			y Yes or No- an, etc.)	Blac	e - Americ ck, White, White		
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P.O. Box 6	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of d	I death 3	Ectopic pregna Other (specify				23d. Dat	e of delive	,	Year
	res that tigned by		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part I	I.	23e. Did tob	acco use contr	ribute to th	e cause of	death?
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>	Attending Physician: ir death. ector: After this certifics by the funeral director. I	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 🗆	ER/Outpatier	nt 3 DOA	0+			rce 6 □Othe	er (Specifi	()	
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Ö	uttendin death. ctor: Aft y the fur	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		, Day 1 ear)	Injury		1 Yes 2	No					
ĭ	r Atte er de recto by th	Certification:	3 Suicide 6 Could not l 4 Homicide determined	286. Place C	of Injury - At he		reet, factory, off	ice	281.	Location (Str. City or Town,	et and Numbe State)	er or Rura	l Route Nur	nber,
	ital or rs afte ral Dir led in	Cer												
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exe	hysician: To the b miner: On the bas	is of examina	wledge, deat ition and/or in	h occurred at th vestigation, in r	e time, date ar ny opinion, dea	nd place, and ath occurred a	due to the car at the time, da	use(s) and ma te and place, a	nner as stand due to	ated. the cause(	s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manne	er stated.			ense number		7	d. Date signed			
	,	_	/ // // ^	OMA	. M.D	) ,		065	D711		0.0 Date signed $0.1$			
	Nt (				(									
			30. Name and address of person who MON(QUE GO	mA,	of death (Iten	H. 18	5101 P	RING	E PH	ILIPI	DR., C	)LNE	4,1	ND
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 2 20	107	gional s oight	*	and I							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month  $P^{M}$ 15, 2:10 Norma Harris Meyers January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Fox Chase Rehab Center Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 578-62-9612 Director 86 July 16, 1920 Atlantic City Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any Injury or other traumattc event, the Medical Examiner must be a 2015 East West Highway 20910 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No if Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert William Harris Alice M. Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Micheline J. Meyers - Daughter 2107 N. Buchanan Ct. Arlington, VA 22207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 02/01/07 4 □ Donation 5 □ Other (Specify) Arlington, VA Arlington Cemetery 22. Name and Address of Facility Mcguire Funeral Service 21. Signature of Funeral Service Licens 7400 Georgia Ave. N.W., Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Hypotension /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 1 ☐ Yes 21 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 XER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1. ⚠ Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or after within 24 hours at To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

the

2

Medical

(Check only

29b. Signature and title of certifier

JAN

one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2 2007

T Mz

Suresh K. Gupta M.D 9801 Georgia Ave. Suite 220 Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature

Registrar DHMH 17 Rev 1/2001 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-32332

29d, Date signed (Month, Dav. Year)

January 18, 2007

To the Hospital within 24 hours a To the Funeral I

10

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 2 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature, and title of certifier

Loveen

Loveen Puthumana, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 Registrar's Signature

Puthumang MD

29c. License number

D59524

29d. Date signed (Month, Day, Year)

January 19, 2007

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:05A 2007 JANUARY 20, EDNA LORICK MC MILLON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7420 SIMMS LANDING ROAD PORT TOBACCO CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F Yrs. 94 1912 SOUTH CAROLINA Director 065-28-2409 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 X Yes 2 No CHARLES PORT TOBACCO MARYLAND Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö UNITED STATES Iteme 23a 7420 SIMMS LANDING ROAD death Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2K No Specify ģ 3 X Widowed 4 □ Divorced "netural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than INTERIOR DECORATOR INTERIOR DECORATION 10TH GRADE permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Importent: If Item 27 is marked other it any Injury or other fraumatic event, Ita 2006. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD LORICK MARIE JOHNSON LORICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7420 SIMMS LANDING ROAD, PORT TOBACCO, MARYLAND 20677 FREDDIE MC MILLON / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MT.PISGAH CHURCH CEME JAN. 25, 2007 COLUMBIA, SOUTH CAROLINA 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Roomsee Lydia C. THORNTON JOHNSON M00583 22. Name and Address of Facility
THORNTON FUNERAL HOME,
3439 LIVINGSTON ROAD, HOME, P.A. OAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S DISEASE **Physician** /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ARTHRITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 Yes 2**∑** No Division of Vital Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 X No After th 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 | Homicide ō hours after within 24 hours a 1(X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0008370 JANUARY 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. PAUL E. PRITCHETT, SR. 118 LAGRANGE AVE. P.O. BOX 1317 LAPLATA, MARYLAND 20646 32. Rigistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 Registrar

07-00751 James Aaron Mo	nse	•	pe or Print in tate of Maryla						egible.	
	_	I-For State Amend #1 Registrar  1. Decedent's Name (First, Midd		HYS Uter	tilicate di	f Death		2. Date of D	Reg. No. 2	3. Time of Death
Physicia Medical Examin			ES AARON 1	MONSEUR				Month	Day Yea 26, 2007	
· Comment		4a. Facility Name (if not institute 3426 Prices Distillery	_	umber)		4b. City, Town, o ljamsville	or Location of D	eath	4c. County Frederic	
Funeral Director		5. Social Security Number 220-98-7667	6. Sex	7. Age (In yrs. la	ast birthday) 38 <sub>Yrs</sub>	If Under 1 Ye Months Da			Birth(MM/DD/YYYY 9, 1968	9. Birthplace (State or Foreign Country) D.C.
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locat	ion	-			10d Inside City Limits
≥	ō	Maryland Fred	erick	Ija	msvill					1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 3426 Prices D	istillery	Road		10f. Zip Code 2]	754		10g. Citizen of Wi	
death with	Funeral	11. Marital Status  1 Never Married 2 X	Armed F	2 y No		es, specify Cuba	an, Mexican, Pu	(Specify Yes or uerto Rican, etc.)		- American Indian, Black, e, etc.
irs after ural",	2	3 Widowed 4 Di 15. Decedent's Education (Sp	vorced If Yes, Give Yes or Dates: ecify only highest gra	ar **	16a. Deceder	Yes 2 X N		d of work done	Specify: 16b. Kind of Bu	White siness/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ompleted	Elementary/Secondary (0-12			Ü	nost of working li		e retired)		Trimming
5-0036 lled within 7. Hygiene I other than	ပ	17. Father's Name (First, Middle				1111		lame (First, Middle	e, Maiden Surname	
2121 2121 Duld be fil Mental F marked ic event,	To Be	Raymond J. Mon  19a. Informant's Name/Relation			19b. Mailin	g Address (Str		a Davis	lumber, City or Tow	n, State, Zip Code)
MD d 2 sho lith and n 27 is		Raymond J. Mon	seur / Fa							ille, MD 21754
Ore, ges l an of Hea If iter ther tra		20a. Method of Disposition  1 Burial 2 X Crematic	n 3 Removal f	rom State	crematory or ot			Date		City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite njury or other tr	П	4 Donation 5 Other 3		Sm	22. 1	rg Crema	ss of Facility	1/30/07		urg, Maryland
		popul 1	soull )	10	1120	O 1 NORTH	I MARKE'	r st. F	REDERICK.	MES, P.A. MD 21701
Physician /Medical		3a. Part I. Enter the disease, of failure. List only one cause	erreach line!	ne intoxic					arrest, shock, or he	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final diseas or condition resulting in death)		a consequence o		Socialed	with total	illie use		
·	Jer	Sequentially list conditions, if any, leading to immediate		a consequence o	f):					
d sit	Examiner	cause. Enter Underlying Caus- (Disease or injury that initiated events resulting in death) Last	C.	a consequence o	f):					
executed ian and ial - transit	=	X UNPENDED	dAMFNDED.	27,28a-f,	porME o	.86/ <sub>1</sub> 2/21	/O7 TT			
68760, certificate be nding physic se as the bur	/Mec	IF FEMALE: 23b, Was decedent pregnant in	23c. If yes,	outcome of preg	nancy				23d Date of	·
SOX leath	Physician/Medica	past 12 months?  1 Yes 2 No 9 U	4 Preg	nant at time of de	ath -	etal death 3 ther (Specify)	Ectopic pi	egnancy	Month	Day Year
P.O. Best that the degree by the detached for the detache	by Ph	Part II. Other significant cond	itions contributing t	to death but not re	esulting in the	underlying cause	given in Part I			ibute to the cause of death?
cords, P.O. Law requires that has been signed be e 2 should be detail	ted t	<u> </u>						11		Probably 4 V Unknown  Were autopsy findings available
Division of Vital Records, ral or Attending Physician: The law requir is after death al Director. After this certificate has been sied in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed						•	pe	rformed?	orior to completion of cause of death?  Yes 2 No
ital Recienant The scentificate rector, page	Be	25. Was case referred to medic examiner?	Hospital:	Inpatient 2	ER/Outpatien		oe of Death (Ch	neck only one)	Residence 6	A Other Secre
T of Vil	. To	1 Yes 2 No 27. Manner of Death	28a Date		28b. Time of		jury at Work?		be how injury occurr	
Sion Attendir death ctor: A	ation		nding estigation Fnd	1/26/2007		pm	Yes 2 X No			
Divisior Hospital or Attenc 24 hours after death Funeral Director:	Certification:		uld not be ermined 28e. Place (Specify)	ce of Injury - At he Found a	ome, farm, stre at reside	-	e building, etc.	28f. Location or Town	n (Street and Numb 1. State) 3426 LLe MD	er or Rural Route Number, City Prices Distillery
e Hospi 124 hou e Funer letely fil		29a. Certifier 1 Certifying	Physician: To the be					, and due to the ca	ause(s) and manner	as stated
To the within.	Medical	29b. Signature and title of certi	aminer: On the basis and manner ier	of examination a stated.	ind/or investiga		on, death occur	red at the time, da		ed (Month, Day, Year)
		his an	; mi				C.M.E.		January 27	
		30. Name and address of personal line Line MD Applied				ot Daltimas:	MD 24204			
S	ate	31. Date filed (Month, Day,Y	ant Medical Exa	miner 111	iree		;, IVID 21201			
Regis		JAN 3	1 2007	Rolling.	D. Fig.	rocks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 19a State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 1/19/07 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JEANNENERHOOD Day 2.0 **Physician** 10:20 01 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7 North Chester Street Unit D **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec. 16, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Ohio **Funeral** 1 □ M 2 □ F 90 171-07-3300 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Show 10b. County 10d. Inside City Limits ?? is marked other than "natural", or Itams 23a or 28a-f shov traumatic event, the Madical Examinat must be multified at MD Baltimore 1XYes 2☐No Director 7 North Chester Street Unit D 10f. Zip Code **21231** 10g. Citizen of What Country?
United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 So No Specify: Specify: Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Francis van Ormer Catherine Winebrenner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyndia Nerhood Levine/Daughter 7 North Chester Street Unit D, Baltimore, MD 21231 Lynda Nerhood Levine/Daughter
20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation Removal from State Omps Crematory Jan. 24,2007 Winchester, VA `4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee

Post Signature of Funeral Service Licensee

22. Name and Address of Facility

Melvin T. Strider Co., Inc.

PO Box 388, Charles Town, WV 25414

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, supported by the service of the servic Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** GASTROINTESTINAL BLEEDING disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician arts the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as t the attending p IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2 ☑No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D48261 01-20-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JH-10 Falls Rd Lutherville MD 21093 Howard Levy MD (0753 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 25 2007 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of I	Marylar	-	artmer rtificat			and M	-	gien Reg. N	2007	03	198
	Physici	ian	Decedent's Name (First, Middle, La	st)							2. Date of De Month		ay Year	3. Time	of Death
	/Media			REMEDHIN NEC							JANUARY			8	3:00 AM
	Examir	ner	4a. Facility Name (If not institution, given		er)		4b. City,	Town, o	Location of	of Death		4	c. County of Deat	h	
		115	1112 DEVER		A00 (In 186	Inct historias	If Under		ER SPRI		2 D-11 Di-	•	MONTGOMER		
	Funeral Director			10X M 2□ F		last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da	ау, Үөаг	)   Co	hplace (State untry)	a or Foreigi
	~ ~		Usual Residence of Decedent		56						SEPTEMBI	5K Z,	1950 ETI	HIOPIA	
Vland	Mon		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limits
2	1 2	to	MARYLAND MONTGOME	RY		SILV	ER SPE	RING						1 □ Ye	es 2X No
the	128	Director	10e. Street and Number				10f. Zip	Code	<del></del>			10g. C	itizen of What Co	untry?	
<u> </u>	ns 23a or 28e-f show		1112 DEVERE DRIV	Έ					20903				U.S.A.		
-UUSO hours after death with the Marvland	Items Char Col.	Funerai	11. Marital Status	12. Was Decede Armed Force		I.S. 13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Amer Black, White		
و ا	or It		1 ☐ Never Married 2 ☐ Married	1 Yes 2			1 03, 3po		Specify:	, r dente	incari, etc.)		Specify:	9, OC.	
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Z Deli			17. Father's Name (First, Middle, Last	4			BUSIN	ESS C		r's Namo	(First, Middle,		TRANSPORTA	TION	
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should	nd Menta marked imatic ev	2	19a. Informant's Name/Relationship			19h Mailie	no Addross	(Stroot			U WONDAF			"- O- d-)	
Ma			ACHAMYELESH ZEWDI										or Town, State, Z		
d) d	Health a item 27 is other tre		20a. Method of Disposition	E WIFE	20b. F	Place of Dispo	sition (Nan	ne of			ate		RYLAND 209 .ocation - City or 1		
altimore,	11 of 11 of		1 ☑ Burial 2 ☐ Cremation 3 ☐		ite	cemetery, crer	matory or o	ther plac	. 1	- 1001					
	ortan ortan njur		<ul> <li>4 □Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>		CE.	DAR HILL			s of Facility	1/20/	2007	SUI	rland, mar	YLAND	
ם מ	Department of H Important: If ite any injury or ot once.		6/2	_							OME, INC		SPRING, MA		
. č. 1	hysician and Medical xaminer transit the prize transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Due to (or c.	ASTATIC as a conseq as a conseq as a conseq	uence of):	E CANC	ER						Onset and 18 MON	
that the death certificat	by the attending pached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  yes 2  No 9 Unknown  Part fl. Other significant conditions of	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of d	ldeath 3[leath 5[	Ectopic pr	ecify)	o in Dant I		22a Bid t		23d. Date of delik	Day	Year
CICS,	500	d by	, at the other brightness of t	or till deling to doubt	10011101103	aning in the di	ndenying c	ause give	minran.				use contribute to		
	20 00	lete													
VICAL DECOLUS,	ate has page 2	Completed									24a. Was autop perfo 1 Yes	sy rmed?	death?	fo noiselama	
	certi	o Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
5 8	r this ral di		1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatien			7 🗆 1401		e 5 🛛 Resid		6 ☐ Other (Speci	ify)	
ding C	Ih. Afte fune	tio	1 Natural 5 Pending 2 Accident investigatio	28a. Date of fr (Month, I	Day Year)	Injury	м	8c. Injury Work	:?` ∕es 2 □ N		od. Doscribe i	iow inju	ry occurred		
el or Attending	at ig in	Certification;	3 Suicide 6 Could not b	e 28e. Place of	Injury - At he etc. (Specif	ome, farm, str y)					8f. Location (S City or Tox	Street ar	nd Number or Rur e)	ral Route Nu	m <i>ber</i> ,
he Hospitel	in 24 hour he Funere pletely fills	edical	29a. Certifying Pr (Check only one) 1 Certifying Pr 2 Medical Example	nysician: To the be niner: On the basis and manner	of examina	wledge, death	occurred vestigation,	at the tim	e, date and inion, deat	l place, a	nd due to the od at the time,	cause(s date an	) and manner as : d place, and due !	stated. to the cause	(s)
To th	within 2 To the I complet	Σ	29b. Signature and title of certifier		4	1.0	29c	. License	number			29d. Da	te signed (Month,	Day, Year)	
	D		1/11	7	1	10	-	D41	715			JANU	JARY 16, 20	007	
٠			30. Name and address of person who	completed cause o	f death (Iten	n 23a) (Type,	Print)								
			CHITRA VENKATRAMAN,	M.D., 6201	GREEN	BELT ROA	D, SUI	TE U#	3, GREI	ENBEL	r, MARYL	AND 2	20740		
	Sta Registr		31. Date filed (Month, Day, Year)	007 32 egi:	strar's Signa	R A	and I								

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of rtificate of			iene 2 0 0 7	03197
			1. Decedent's Name (First, Middle, Las	st)		-		2. Date of Deat Month		3. Time of Death
	Physici /Medic		Janet Patricia	Nose1				January		1:28 P M
	Examin		4a. Fecility Name (If not institution, give		)	4b. City, Town,	or Location of Death	1	4c. County of Death	1
			St. Mary's Hos  5. Social Security Number 6. S		ge (In yrs. last birthday)	Leonar If Under 1 Yea		0 Date of Birth	St. Mary	s
	Funeral Director				76 Yrs.	Months Days		August	4, 1930 Per	nplace (State or Foreign Intry) Insv1vania
			Usual Residence of Decedent							
	how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	88-10 188-10	Director	Maryland ST. M	arys	Mechani					1 ☐ Yes 2 No
	with ti		10e. Street and Number	D .		10f. Zip Code		1	0g. Citizen of What Co	untry?
	eeth	erai	39401 Pocahontas	Drive 12. Was Deceden	t Ever in II S 13	Was Decedent of	Hispanic Origin? (S	necify Vos or No-	USA 14. Race - Amer	ican Indian
Maryland 21215-0036	d within 72 hours after deeth with the Maryland Jione. I than "naturel", or iteme 23a or 28e-f ehow The Macincal Examinar must be notilied at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1 Yes 2  If Yes, Give  Year or Dates:	? ] No	If Yes, specify Cu	ban, Mexican, Puert	o Rican, etc.)	Black, White	, etc.
ဝို	72 ho	Completed by	15. Decedent's Ec	ducation	16a. Dece	dent's Usual Occi	upation e during most of wor	tina	16b. Kind of Business/l	ndustry
2	within 72 ene. than "nai	nple	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retir	ed)	x#ig		
2	e filed within al Hygiene. I other than vent, the Me		12 17. Father's Name (First, Middle, Last)		Homem	aker	10 Manharia Nasa	- /First 14iddl- 1	At Home	
and	0 = 0 =	Be c	William Jerz					ne (First, Middle, A	valuen Surname)	
<u>Z</u>	2 should and Men ie marke	ည	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Stree	Anna G1		City or Town, State, Z	ip Code)
	all ha		Denise Hudson/dau	ghter					csville, MI	
Baltimore,	of Head of Head fitem		20a. Method of Disposition  1 Burial 2 Tremation 3	Pomovol from State	20h Place of Dispe	osition (Name of		The state of the s	20c. Location - City or	
Ĕ	permit. Pages 1 e Department of He important: if them eny injury or oth		4 □ Donation 5 □ Other (Specify		Diffisite			3, 2007 (	Charlotte H	MD MD
Ball	bepart nport ny in		21. Signature of Funeral Service Licer	ISBB.			ress of Facility ${ m Br}$	insfield-	-Echols F.H	I., P.A.,
	40 = e d		220 Part Folor the diagram or com	X Con Y					rlotte Hall	·
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.		ring, such as cardiad	or respiratory arre	981,	Approximate Interval Between Onset and Death
j.	Physician /Medical		disease or condition resulting in death)	a	S a consequence of):	IYMIA				MINUTES
	Examiner				ONIMA RECU	ly Dis	6846			Y
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	D	s a consequence of):	(1 01)	Cuse			JEATS .
	cate be executed physicien and the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
9	oe exe		resulting in death) Last	Due to (or a	s a consequence of):					
8760,	cate t	dicai		d						
Box 6	eath certific ettending p for use as 1	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ter			23d. Date of deli	/ery
P.O. B	The law requires that the death certificate be executed to be been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			⊒Ectopic pregnan ⊒ Other (specify)	су		Month	Day Year
	es that igned b	by P	Part II. Other significant conditions of	ontributing to death	but not resulting in the u	inderlying cause g	iven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ğ	w require been sig should b	per	Status Past Coron	IARY ARTGE	Y BYPASS (	SPAFTING	600	1 □ Ye	es 2 No 3 Pro	bably 4 Unknown
Vital Records,	lawre es be	Completed	Stenis YEARS	160.				24a. Was ar	n 24b. Were au	opsy findings available ompletion of cause of
E H		Con						perform	ned? death?	2□ No
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		10	44	th Check only on		
o to	Phys r this ral dii	10	1X Yes 2 □ No 27. Manner of Death	1 ☐ Inpat		III JU DOA			nce 6 Other (Spec	ıfy)
on	th. : After s tuner	tlon	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year) Injury	W	ork? □Yes 2□No	200. 2000/100 110	www.mary occurred	
Division of	r Attendi er death. rector; A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, larm, st etc. (Specify)	reet, lactory, office	)	28f. Location (Sti City or Town	reet and Number or Ru	ral Route Number,
	ital o Irs aft rel Di Iled in			1						
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director; After completely filled in by the fune.	Medical	29a. Certifier (Check only one)  Certifying Ph 2 Medical Exer	ysician: To the bes niner: On the basis and manner s	t of my knowledge, deal of examination and/or in stated.	h occurred at the vestigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licer	nse number		9d. Date signed (Month	, Day, Year)
,						D	00(5(63	-	DANUARY 20	2007
(	NAT		30. Name and address of person who PICTER ESTERHAY	completed cause of	0			~ ~ ~		
1	Sta	te	31. Date filed (Month, Day, Year)		11. 620.061		, LEONARD	IM LUNET	<u> </u>	
ţ	Registi		JAN 2 2	2007	trar's Signature	beck				

Registrar
DHMH 17 Rev 1/2001

State

e of death (Item 23a) (Type, Print)

904

2. Registrar's Signature

Name and address of person who completed ca

31. Date filed (Month, Day,

		1 - For Registrar	State of I	Marylan	-	artmer rtificat				lental Hyg	jiene leg. No.	2007	03199
		Decedent's Name (First, Middle, Last	t)							2. Date of Dea	th		3. Time of Death
Physic /Medi		ALICE JEANE POM	RANING					-		Month January	Day 7 25	2007	12:15 P M
Exami		4a. Facility Name (If not institution, give	street and numb	er)		4b. City,	Town, or	Location of	of Death			ounty of Dea	
		Eagle View Assist						efor				arford	l 
Funeral Director		103-10-0930	7. □ M 20XF	Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 9/21/19	Year) 922	C	thplace (State or Foreign ountry) nsylvania
and *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
death with the Maryland me 23a or 28a-f ehow rmust be notified at	ō	PA York			elta								1 ☐ Yes 2 ☑ No
the h	rect	10e. Street and Number		De	illa	10f. Zip	Code				Og Citize	on of What Co	11
3a or	0	462 Slab Road					1731	.4			US		
s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No-	14	I. Race - Ame	
after or its	Fu	1 Never Married 2 Married	Armed Force 1 Yes 2 t Yes, Give			_				Rican, etc.)		Black, Whit	
hours after tural', or its	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:		1 🗆 Yes	ZIŽI NO	Specify:			S	Specify: W	Mite
72 h	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ition <i>uring m</i> osi	t of worki	ng	16b. Kind	of Business	/Industry
within ene. then "	I d	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo not u makei		)			0	wn Hom	ne
12 should be filed within hand Mental Hygiene. 7 is marked other then "renmatic event, the Men		12 17. Father's Name (First, Middle, Last)						10 Moths	ria klama	(First, Middle,	Maidae C		
ntal led o	Be										Waluell Si	urname)	
mark mark	2	Samuel Haugh  19a. Informant's Name/Relationship (7)	vne Print)		19h Mailie	na Address	(Street 2			Kilgore  I Route Numbe	Ciby or 1	Town State	Zin Code)
nd 2 salth an 27 is r treu		Bailey D. Pomr		chand								TOWN, State, a	zip code)
is 1 and Heal	-	20a. Method of Disposition	aning/nu	20b. P	lace of Dispo	Slab sition (Nar.	ne of	1	-	ate I/C		ation - City or	Town, State
Peges nent of nt: If it ry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		sa i	emetery, crer Lem Ce	matory or o		1,	/29/	2007		a, PA	,
		21. Signature of Funeral Service Liceo				. Name an	-	- 1					
permit. Departr Import. eny tnj		X Lellaur P.	- Francis	1. 1	//					e, Inc.,	De1	ta, PA	17314
		23 13 1. Extended the dise se, or companied, or heart failure. List only	lications that caus	sed the deal	1								Approximate
Ster Box		Immediate Cause (Final	ne cause on each	line.	121		Te l		7/0	1-1	2 -		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a		1 4 / /	10	, K	>		8日5	85		OVER 24
Examiner			Due to (or	as a conseq	uence of):								
	<u>e</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consequ	uence of):								
d Insit	ᇤ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		·	•								
icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of);								
e be /sicie	dicail		d										
	0	Para	u										
attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			3					230	d. Date of del	ivery
daati e atte	icia	in the past 12 months?	1☐Live birth 4☐Pregnant	at time of de		Ectopic pr Other (sp						Month	Day Year
that the da led by the a deteched	hys	9 Unknown	9□ Unknown	1							,		
The law requires that the daath certifi ste hes been signed by the attending t page 2 should be deteched for use as	by P	Part II. Other significant conditions of	ntributing to death	but not resi	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did tol	oacco use	contribute to	the cause of death?
w require been sign	edi									1 □ Ye	s 2 🗆	No 3 Depr	obably 4 Unknown
aw requisible by should	Completed									24a. Was a		24b. Were au	utopsy findings available
The tay	E									autops	ned?	death?	completion of cause of
	Bec	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes :	-	TUTES	2 No
	To B	examiner? 1 🗌 Yes 2 🗓 No	Hospital:	ıtient 2□	ER/Outpatien	t 3□ DO	A Othe					Wither (Sne	SSISTED
		27. Manner of Death	28a. Date of In (Month, I		28b. Time of		8c. Injury Work			8d. Describe ho			LIVING
Attendin death. ctor: Afr y the fur	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	(MOIIII, I	Day ( ee/)	Injury	м		es 2 🗆 N	No				
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of building,	Injury - At ho	ome, farm, str	et, factory	, office		2	28f. Location (St City or Town	reet and f	Vumber or Ru	iral Route Number,
rs aft	Cer		Dunding,	olc. (Specify	"					Only of Town	i, Siale)		
To the Hospital or within 24 hours after To the Funerel Dir completaly filled in		29a. Certifier 1 Cartifying Phy	sician: To the be	st of my kno	wledge, death	occurred	at the tim	e, date and	d place, a	and due to the ca	ause(s) an	nd manner as	stated.
he H in 24 he Fi pleta	Medical	(Check only 2 Medical Examone)	and manner	stated.	tion and/or inv	estigation,	in my op	inion, deat	h occurre	ed at the time, d	ate and pl	ace, and due	to the cause(s)
With To t	Σ	29b. Signature and title of certifier	11				. License	number	-	2	9d. Date s	signed (Monti	h, Day, Year)
		1 Kutu a	·	Não	8	L	10C	16	38	9 -	JAZ	WARY	126.2007
a		30. Name and address of person who o	ompleted cause o	f death (Item	23a) (Type,	Print)			/		^	- !	7. Day, Year) 1 26, 2007 TE105 FALLST HOLICIT,
8		YEK PECTO C	·VALI	-KA	DIN	(10.	i	7/6 1	TAR	FORD	ROA	DSUI	TELOS FALLS
Sta		31. Date filed (Month, Day, Year)	32 Regi	strar's Signa	ture								HOHOLL
Registi	rar	EED A 5 20	07		Y And	22.63 1							,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Donald Dean Pfeiffei
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onald Boarr .		1- For State Registrar		icate of Death	id Wierita		200°	7 0320
Physicia Medical Exami		Decedent's Name (First, Middle, Last)  Donald Dean Pfeiffer				2 Date of Death Month January 22		3. Time of Death 0815 hrs
neuicai Exaiiii	nei	4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of D		, 2007 4c. County of Death	
		Western Maryland Hospital Center		Hagerstow			Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age 485–22–7850 1 M 2 F Usual Residence of Decedent	(In yrs. last t	birthday) If Under 1 Ye Months Da			(MM/DD/YYYY) 9. Birt 0, 1927 Foreig Cou	hplace (State or n untry) Iowa
япу			0c. City, Tov	wn or Location				10d Inside City Limits
daryland 28a-f show any 1 at once.	ē	Maryland Washington		Hagerstown	า			1 Yes 2 X No
th the Maryland 23a or 28a-f sho uotified at once.	Il Director	10e. Street and Number 11340 Lakeside Drive			21740		g. Citizen of What Cour	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Memal Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f she traunatic event, the Medical Examiner must be notified at once	y Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year	7 No. 48	13. Was Decedent of H If Yes, specify Cuba  1 Yes 2 X N	an, Mexican, Pi		14. Race - Americ White, etc. Specify: WI	nite
ours a ratura Aamir	ed by	15. Decedent's Education (Specify only highest grade comp	leted) 16	ia Decedent's Usual Occup- during most of working life			16b. Kind of Business/I	ndustry
21215-0036 uld be filed within 72 hours a Mental Hygiene marked other than "natura c event, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	•)	Inspecto	or	, i	Truck Mfg	g.
e, MD 21215-003 I and 2 should be filed within Health and Mental Hygiene item 27 is marked other the r traumatic event, the Med	Be C	17. Father's Name (First, Middle, Last)  Leo H. Pfeiffer Sr.				Name (First, Middle, Ma Betty LaPo	alden Surname) 1e Pfeiffei	r
212 ould bo if Ment is mark	To E	19a. Informant's Name/Relationship (Type, Print )	$-\tau$	19b. Mailing Address (Stre	eet and Numbe	er or Rural Route Numb	per, City or Town, State,	Zip Code)
MD nd 2 sho alth and m 27 is aumati	Ĩ	Mary Ellen Pfeiffer (wife)					town Maryla	
Baltimore, MD 2121 permit. Pages I and 2 should be fit Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event.		20a Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:	crem	ee of Disposition (Name of contactory or other place) thsburg Crema	- 1	Date 1-24-2007	20c Location - City or Smithsburg	g Crematory
Salti ermit. epartn mport njury		21 Sa nature of Funeral Service Licensee	•	22. Name and Addres	ss of Facility	Douglas A.	Fiery Fund	eral Home
Physician		23a Part I. Enter the disease, or complications that caused the	ne death. Do	11331 Faste	ern Bld	vd. N. Hage	erstown Mary	v1and 21742
/Medical		failure. Listonly one cause on each line.		otic Cardiovascular D				Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence)						
	F	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence)	Theore of).					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						-
nted d ansit		events resulting in death) Last   Due to (or as a conseq d.	luence of):					
e executed tian and ial - transit	Medical	UNPENDED AMENDED						_
760, icate be exphysician the burial		IF FEMALE: 23c. If yes, outcome	of pregnan	су			23d. Date of delivery	
ox 68 ath certifi attending or use as	cian/	past 12 months?	me of death	2 Fetal death 3 5 Other (Specify)	Ectopic pr	regnancy	Month D	ay Year
Box 68 e death certif the attending	Physic	1 Yes 2 No 9 Unknown 9 Unknown		5 Other (Specify)				
P.O.	þ	Part II. Other significant conditions contributing to death	out not result	lting in the underlying cause	given in Part I		acco use contribute to t	
Division of Vital Records, rate of an equir radice death as after death al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Completed				-	24a. Was ar autops		opsy findings available ompletion of cause of
tal Reco	mo;					perform 1 <b>Y</b> es 2		s 2 No
tal F cian: certifi	Be	25. Was case referred to medical examiner?			ce of Death (Ch			
Physican this	4	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 27 Manner of Death 28a. Date of Injury		t/Outpatient 3 DOA	Other N		tesidence 6 Other:	
ion c tending eath or: Aft the func	tjou	1 Natural 5 Pending (Month, Day, Yea			Yes 2 No		www.mary documen	
ivision or Attendafter death Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ry - At home	e, farm, street, factory, office	building, etc.		reet and Number or Rur	al Route Number, City
Di spital ours a filled	Cert	4 Homicide determined (Specify)				or Town, Sta	ate)	
Di To the Hospital within 24 hours a To the Funeral		29a Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner						
To t To t	Medical	and manner stated.  29b. Signafure and attended to experiment			se number		29d Date signed (Mon	
		AJUAN IV			.M.E.		January 23, 2007	
		30 Name and address of person who completed cause of dea	ath (Item 23a	a)				
H-9+1		Susan Hogan MD. Assistant Medical Exa		111 Penn Street, Ba	Itimore, ME	21201		//
St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar's	s Signature	Anasked				

			For State	State o	of Marylar				d Mental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle	[ ast]	<del></del>	Cei	tificate of	Death	2. Date of De	Reg. No. 2	07	3. Time of Beath
П	Physici /Medic		FAY L.	POVICH					Month JANUARY		Year	9:51A M
100	Examir		4a. Facility Name (If not institution	, give street and nu	ımber)		4b. City, Town,	or Location of D	eath	4c. County o		
			SUBURBAN HOSPI		7.4.0		BETH		Han I a min to	MONTGO		
	Funeral Director		5. Social Security Number 195-10-2206	6. Sex 1 ☐ M 2X☐ F	7. Age (In yrs. 93	Yrs.	Months Days		Hrs. 8. Date of Bin Month, Da JUNE 6,	1913 P	9. Birthpl ENNSY	lace (State or Foreign
14.	p		Usual Residence of Decedent									
	anylar show	'n	10a. State 10b. County  MARYLAND MONTGO	MERY		ty, Town or Lo ROCKVILLI					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M 28a-f rotifie	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	hat Coun	**
	h with		1801 EAST JEFFER	SON ST	#410			852		UNITED STAT		•
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show marked other than "stanner must be notified at imatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced	Armed Fo	2 [XNo ive		Was Decedent of f Yes, specify Cut I ☐ Yes 2Å No	oan, Mexican, P	I ? (Specify Yes or No uerto Rican, etc.)		- America , White, 6 WHI	etc.
5-0	72 h "natu dleal	etec	15. Decedent (Specify only highes	's Education at grade completed)		(Give	lent's Usual Occu kind of work done	during most of	working	16b. Kind of Busi NATIONAL I	iness/Ind LNSTI7	lustry CUTE
121	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)		OO NOT use retire ISOR OF RE	*	STS	OF HEALTH		
<b>J Q</b>	e filed Il Hygi other /ent, tl	Be C	17. Father's Name (First, Middle,	Last)		1		18. Mother's	Name (First, Middle	, Maiden Surname	)	
ylar	2 should be and Mental is marked o sumatic eve	ToE	HENRY LEVINE					I	ENA SHULTZ			
Mar	- cd ca =		19a. Informant's Name/Relations				-		or Rural Route Numb		tate, Zip	Code)
	of Health of Health of Health of Item 27 is		HENRY D. KAHN -  20a. Method of Disposition	NEPHEW	20b. F	Place of Dispo	0 WHISPERW sition (Name of	1	Date	20c. Location - C	city or To	wn. State
ШÖ	0 0		1  Burial 2  □Cremation 4  □Donation 5  □ Other (S		State	-	natory or other pla RIAL GARDE	· i · ·	L/ <b>1</b> 9/07			RYLAND
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service						HINES RINAL AVE, SILVER			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	h. Do not ent	er the mode of dy	ing, such as car	 rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one cause on c	107000	e a reconstruction						Onset and Death
Jan Alija	/Medical Examiner		resulting in death)	Due to	(or as a conseq				dement			
Ŀ		er	Sequentially list conditions,	b	(or as a echasi		1712ha	meis	diment	ia		
	nd ransit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с								
8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):						
587	ficate   physi s the b	edical		d								
.O. Box	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 moorts? 1 ☐ Yes 2 to to 9 ☐ Unknown	1 ☐Live	itcome pf pregna birth 2 □ Feta nant at time of d nown	al death 3	]Ectopic pregnand ]Other <i>(specify)</i> _	ey .		23d. Date Mont		ry Day Year
ď.	res that igned b be deta	by Pr	Part II. Other significant condition	ns contributing to d	leath but not res	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did	tobacco use contrib	ute to th	e cause of death?
ord	w require been sig should b	ted k	- Hypente	sim					_ 10	Yes 2.[X]No 3	, ☐ Proba	ably 4 □Unknown
or Vital Records,	e law r nas be e 2 sh	Completed	arithrit	is					24a. Was	an 24b. We	ere autop	osy findings available inpletion of cause of
al F			prem	رما					perfo 1□ Yes	ormed?   de	eath?	2 🗆 No
ΖĦ	Se Se	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	EB/Outpation	t all pos Oti	nor.	Death Check onl			
on or	ing Affel une		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Mor		28b. Time of Injury	28c. Inju	4 LI Nursir	ng Home 5 ☐ Resi 28d. Describe	dence 6 LIOther		)
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	e of injury - At he ling, etc. <i>(Specil</i>	ome, farm, str fy)	eet, factory, office	1100 2 110	28f. Location ( City or To	Street and Number wn, State)	or Rural	Route Number,
_	Hospita Hours Funeral tely fillec	Medical Co	29a. Certifier 1 Certifyin (Check only one)	<b>Examiner:</b> On the b	e best of my kno casis of examina	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and p opinion, death o	place, and due to the occurred at the time	cause(s) and mani date and place, ar	ner as sta nd due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	. 11		<u> </u>	29c. Licen	se number		29d. Date signed (	(Month, L	Day, Year)
	12		<b>)</b>	/Volle	ogn	w	DO	0610	34	1/10/1	DI	
			30. Name and address of person				Print)	T LEVET	T. ROCKVI	ILLE, MARYL	AND 2	0852
	Sta	ite	31. Date filed (Month, Day, Year)		egistrar's Signa			,				
	Registr	rar	IAN 2.2	2007	MILE	T. BY						

			Please Type or Print in Bla			-	_	ible.			
			1 State		artment of Health and	Mental Hy	giene	207 0220			
			Registrar	Cel	tificate of Death		Reg. No. 4	301 0320			
н	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	eath Day	3. Time of Death				
	/Medi		MABEL VIRGINIA PHUCAS		4b. City, Town, or Location of De	Januar	*	2007 4:25 P <sup>M</sup>			
	Exami	ner	4a. Facility Name (If not institution, give street and number) 9103 Travener Circle		**	ain		y of Death			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	Frederick If Under 1 Year   If Under 24 F	rs. 8. Date of Bi	rth	ederick  9. Birthplace (State or Foreign			
т	Director		214-82-6685 1 1 M 2 M F 91	Yrs.	Months Days Hours M	in. (Month, Di Nov. 7		Country) Virginia			
	p		Usual Residence of Decedent			1.5.0	, 1,15	, 11 Sinia			
	anylar show d at	Ļ	10a. State 10b. County 10c. City, T	Town or Lo	cation			10d. Inside City Limits			
	Ba-f	Sch		deri				1 ☐ Yes 2K No			
	with the	Ē	10e. Street and Number 9103 Travener Circle		10f. Zip Code			What Country?			
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ont, the Medical Examiner must be notified at	<b>Funeral Director</b>		10.1	21704	/Cit- VN	U.S.	A . ce - American Indian,			
	Item Iner	Ë	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1. □ Never Married 2 □ Married	13. V	Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	0- 14. Na Bla	ck, White, etc.			
336	al", or	b	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:	i	I ☐ Yes 2 ☒ No Specify:		Speci	<sub>fy:</sub> White			
Ş	2 hou	Completed	15. Decedent's Education	16a. Deced	lent's Usual Occupation		16b. Kind of E	Business/Industry			
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21	ed with ygiene. er thar t, the N	5	12	1	Homemaker			Home			
nd	be file tal H d oth even	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle	e, Maiden Surna	me)			
<u>y</u> a	should be filed wand Mental Hygies marked other tourmatic event, the	ြင	Charles D. Fletcher			e Wine					
Maryland 21215-0036					g Address (Street and Number or			,,			
	1 and 2 Health tem 27 i				Travener Circle	Frederi		yland 21704 - City or Town, State			
ğ	ages nt of t: If it	1			sition (Name of natory or other place)						
Baltimore,	artme artme ortan		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		coln Cemetery 01			ood, Maryland			
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		No. A	HI	Name and Address of Facility NES-RINALDI FUN 800 New Hampshi	ERAL HOME	INC.	MD 2000/			
F			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failule. List only one cause on each line.	Do not ente	er the mode of dying, such as care	iac or respiratory a	arrest,	Approximate Interval Between			
	Physician		Immediate Cause (Final Days 1					Onset and Death			
	/Medical		disease or condition resulting in death)  Renal Fallure  Due to (or as a consequence)			· · ·		2 years			
	Examiner		Nephroscleros	is							
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Arteriosclero	nce of):							
	ecute and trans	Examiner	triat lintated events								
760,	be ex	al E	resulting in death) Last Due to (or as a consequen	ice orj:							
687	The law requires that the death certificate be executed the has been signed by the attending physician and lage 2 should be detached for use as the burial-transit.		d		<u> </u>						
×	certifi Iding Se as	Physician/Medi	IF FEMALE: 23c. If yes, outcome pf pregnance	v			004 5	4-416			
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time of deat	eath 3	Ectopic pregnancy Other (specify)			ate of delivery onth Day Year			
P.O.	t the carbon the achec	hysi	9 ☐ Unknown 9 ☐ Unknown								
	ires that the de signed by the a be detached i	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	iderlying cause given in Part I.	23e. Did	tobacco use con	tribute to the cause of death?			
rd	w require been sign	ed	Hypertension			_ 1 🗆	Yes 2⊠ No	3 ☐ Probably 4 ☐ Unknown			
ပ္ပ	has be	plet	Hyperlipidemia			24a. Was		Were autopsy findings available prior to completion of cause of			
or Vital Records,		Completed				perfe 1□ Yes	ormed?	death? 1 □ Yes 2 □ No			
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			eath (Check only	one)				
20		P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ inpatient 2 ☐ ER			Home 5 X Res					
n C	Jing F	ioi	1 ☑ Natural 5 ☐ Pending (Month, Day Year)	3b. Time of injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe	how injury occur	rred			
Division	death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home	farm etro		28f Location /	(Stroot and Num	ber or Rural Route Number.			
Σ	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	on, radiory, office	City or To	wn, State)	ber or Harar House Warniger,			
	splta nours neral y filled		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death	occurred at the time, date and pla	ace, and due to the	cause(s) and m	anner as stated.			
	he Hc in 24 he Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	n and/or inv	estigation, in my opinion, death o	ccurred at the time	, date and place,	, and due to the cause(s)			
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signe	ed (Month, Day, Year)			
)	le		Suber . algert		D-00143-MD		January	y 19, 2007			
			30. Name and address of person who completed cause of death (Item 23								
	C+	ate	Hubert J. Alpert, M.D., 8630 Fe	enton	street, Silver	Spring,	Maryland	1 20910			
	Regist		31. Date filed (Month, Day, Year)  JAN 2 2 2007  31. Pegistrar's Signatur	A	ME						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** David Garth Perry, Sr. 20, 2007 January 11:45 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Frederick Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 217-28-1626 72 1934 Maryland June 13, Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 XNo Directo Montgomery Maryland | Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20501 Greenfield Road 20876 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 □ No 1 ☐ Yes 2 X No Specify: Completed by Year or Dates: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) 12 Deputy Sheriff Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be C. Perry, Sr. Harry Nannia Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Perry -Wife 20501 Greenfield Road, Germantown, Maryland 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematorium 1/22/07 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Overt 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical Due to (or as a consequence of): Examiner NCE PHALOPATHY VENE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the ettending physicien and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MENIN GITIS cate has been sig 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No To the recent of the death.

Within 24 hours effer death.

To the Funeral Director: After this certification of the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Hatural 5 Pending 1 □Yes 2 □No М investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047951 01-22-2007 MM WIT 12+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE FREDERICK MD 21701 HOUSE 314 TOLL A KAZMI, HO 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State Been It Sparts Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 27, 2007 **Physician** 12:20pm Rice Judy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Beverly Living Center of Cumberland Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Oct 12, 1942 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 25 F 234-68-2505 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examination must be notified at Cumberland MD Allegany 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 21502 USA 135 N. Mechanic Street Apt. 207 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) First Un. Bank & Trust Bank Teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; If Item 27 1s marked t any lighty or other traumatic eventage. Wanda Copeland Wilmer Crosco ပ 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 135 N. Mechanic St. Apt. 207 Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Glenn Rice husband 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Restlawn Memorial Gardens 1/30/2007 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature - Funeral Service Licensée <sup>22. Nam</sup>Scarbelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eg 05 Metasta Dreaut **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titlerof certifier D0060478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENT AVE. CUMBER 625 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene ( 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 10:158 M 200 anuary Thelma May RITCHIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 136 East Washington Street Hagerstown Washington If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🕅 F 73 Director Sept. 16 1933 Maryland 217-28-7193 Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a. State 10b. County r then "naturs!, or itams 23s or 28s-f show the Medical Examinar must be notified at Yos 2☐No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 136 E. Washington Street USA Pages 1 and 2 should be filed within 72 hours after death inent of Heelth and Mental Hygiene. Int. If Item 27 is marked other then "netural", or Items 23 Completed by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X tf Yes, Give Year or Dates: 2X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) Dress Mfg 10 Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Albert Reed Dorothy F. Walls 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2. Depertment of Heelth a important: if itsm 27 is eny injury or other treu once. 619 Bayshore Dr. Unit #55 Ocean City, Md. 21842 of Disposition (Name of Date 20c. Location - City or Town, State Harold G. Spigler Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 1/27/07 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signatur - Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiovascular disease Immediate Cause (Final 4theroscerotic 10 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform (3) 1 Yes 2 No anemia 1 ☐ Yes 25. Vas case referred to medical examiner? 26. Ptace of Death (Check only one) Be Hospital: 1 Inpatient examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death i or Attending P efter death. Director: After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital c within 24 hours of To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10017591 German & M.D. 30. N e nd addres of person who impleted cause of death (Item 23a) (Type, Print) 1110 Medical Campus d. 13H-25 George C. Newman II, M.D Suite 130 Hagerstown, Maryland 21742 31. Date filed (Month, Pay Year) 32. Registrar's Signature State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 21 William Ralph Ruck 2007 3:57 PM JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown If Under 1 Year 1 If Under 24 Hrs Washington County Hospital Washington County 9. Birthplace (State or Foreign 5. Social Security Numb 8. Date of Birth (Month, Day, Ye March 10 age (In vrs. last birthday **Funeral** 1 M 2 □ F Months Davs Hours 5<sup>ear</sup>1950 Maryland 220-52-1469 56 Director Usual Residence of Decedent 10c. City. Town or Location 10h. County 10d. Inside City Limits a or 28a-f show t be notified at 28a-f show Pennsylvania Franklin Greencastle 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17225 12089 Crestview Drive U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or thems 23a any lajury or other traumatic event, the Medical Example. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Metal Fabrication Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Elizabeth Beaver Ruck William Henry Ruck, Jr. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17225 19a. Informant's Name/Relationship (Type. Print) Kimberly S. Ruck (wife) 12089 Crestview Drive Greencastle Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem Park 1-25-2007 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home wy for 1331 Eastern Blvd. N. Hagersotwn Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepan /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 No. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe mobile Eter Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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mill

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

JAN 22, 2007

and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of M	/larylar		artmeni tificate			and M	ental Hy	giene	' U U /	03207	1
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Maryland 21215-0036			19a. Informant's Name/Relationship (7) Jane Roseman/Wife								rf. MD		or Town, State, 2 02	(ip Code)	
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	Funeral Director	ų.	5. Social Security Number 215-26-2206 Usual Residence of Decedent	6. Sex 12 M 2 F	7. Age (In yrs. <b>87</b>	last birthday) Yrs.	If Under 1 Y Months D	ear If Und	der 24 Hrs. S Min.	8. Date of Bir Jan 1,	1920	9. Bir	hplace (State o	nr Foreign
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3altimore,	Se to L		20a. Method of Disposition  1  Burial 2 □ Cremation  4 □ Donation 5 □ Other (5		State Roc	Place of Dispo cemetery, crer cky Gap	sition (Name in atory or other leterans	of Ir place) Cemete	ery 2	2/1/2007		cation - City or tstone	Town, State	D
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	20		30. Name and address of person	who completed cause	se of death (Ite	m 23a) (Type,	Print)	7	) Civi	2 1.	mho	dan	MA	) CN N
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			1- State of Maryland / Dep	eartment of Health and Nertificate of Death		ene () () 7	03209
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Curtis E. Stine, Jr.		Jarma	Day th Year M 30 2007	12.00 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	
			8204 Redmiles Ln.	Odenton	.	Anne Arund	el
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y. 9/4/1936	9. Birthp	lace (State or Foreign
h.	Director		220-32-2866 <sup>1</sup> ∇ <sup>M 2□ F</sup> 70 Yrs.	Monard Bayo Hours Islant.	9/4/1936	Mary.	l'and
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<u>Y</u>	Men Men Marke Marke	ပ	Curtis E. Stine, Sr.	Reba C			
Var	d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "; traumatic event, the Med			ing Address (Street and Number or Run			Code) 113
<u>.</u>	1 and Health		Margaret Redmiles (Daughter) 820  20a. Method of Disposition 20b. Place of Disp		enton, Ma		
ō	iges if ite or of		1 Surial 2 ☐ Cremation 3 ☐ Removal from State	omatory or other place) Chapel Cemet. 2/2/		c. Location - City or To Churchville	
Baltimore, Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ortainent of Health and Mental Hygiene. ortaint: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examinating the multiled at a.						, 1.11.5
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Once.		*Kuskn Hous angusber	2 Name and Address of Facility Tarring-Cargo Fune Aberdeen, Maryland	ral Home, 21001-3	399 <sup>A</sup> •	
П			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardiony	iere		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		3855 <b>(15</b> 8		
	LXUIIIIICI	ابا	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	(andronus	Opy la	7	
-	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	U	199		
	xecul and al-trar	Examiner	that initiated events c. Due to (or as a consequence of):				
8760,	icate be executed physician and s the burial-transit	dical					
9	tificati ig phy as the	edic					
Вох	eath certifi attending   for use as	M/	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
	the atte	icia	1 Ves 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	that the de ed by the detached	Physician/Me	9 Unknown				
	es gu	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the	
Vital Records,	w requir been si should	Completed	CVYYBOOK C (CCC. TOCK) DI	as war	Yes	2 □ No 3 □ Proba	ibly 4 Unknown
ec.	e law has b	npi			24a. Was an autopsy performed	24b. Were autop	sy findings available inpletion of cause of
al						d? death? YNo 1 ☐ Yes	≫ <b>∑</b> No
Σ	ysician: The is certiticate hadirector, page	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	(Check only one)		Daughters
oţ	문 등 je	1: To	1 ☐ Yes 2 ☐ No	III 3 DOA 4 Nursing Ho	me 5∐Residenc 28d. Describe how i	e 6 <b>X</b> Other (Specify)	nome
on	Attending Physician: r death. sctor: After this certitic by the funeral director.	tior	11 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		. ,	
Division of	Attending death.	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural	Route Number,
	tal or A s atter al Dire ed in by	Certification:	4 Homicide Scientified building, etc. (Specify)		City of Town, 3	nate)	
1	Hospital or 24 hours atte Funeral Dir tely tilled in I		29a. Certifier (Check only 2 Medicel Examiner: On the basis of examination and/or in	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
1	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Atter completely tilled in by the tuner	Medical	one) and manner stated.  29b. Signature and title of pertifier	29c. License number		Date signed (Month, L	
$\subseteq$	⊢ s ⊢ ŏ		my Links	D51596		()	
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	. Print)	701	ruary 31° C	٩٥٥).
_	-0		K. Ambalavarar, 7845 Oak	wood Road, 103	, alen E	Bernie n	10016
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hails I			
	Registr	ar	FEB 0 5 2007 Blocker 15 1	Section 1			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 9,2007 William Woodrow Stouffer Jan. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Months 1**X** M 2 □ F 64 29 1942 Maryland 217-42-9647 May Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 No Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21742 13846 Marsh Pike U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 10/ If Yes, Give Year or Dates: 03/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 10/1962 03/1969 1 Never Married Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contracting Owner 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Richard Stouffer Lois Beachley Stouffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 13846 Marsh Pike Hagerstown Maryland 21742 Carol Thumma Stouffer (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State Jan 24 07 Hagerstown Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis secondar Due to (or as a consequence of): e12 ai Sequentially list conditions, if any leading to immediate Due to (or as a consequence of)

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

**Physician** 

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar months.

dical Examin	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consequent	uence of):					
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23d. Date of delivery Month Day Year				
급	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tob	acco use co	ontribute to the cause	e of death?
d b	Dehydraican				1 □ Ye	s 2 No	3 Probably	4 ☑Únknown
Somplete	SuBorachnois	n 24 y ned?	b. Were autopsy find prior to completion death?					
Be	25. Wa case referred medical			26. Place of Dea	ath (Check only on	e)		
0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐Inpatient 2 ☐	ER/Outpatient 3 ☐ I	OOA Other: 4 Nursing H	lome 5 Reside	nce 6 🗆 0	Other (Specify)	
ation: T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occ	curred	
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fact y)	ory, office	28f. Location (St City or Town	reet and Nu , State)	mber or Rural Route	Number,
Medical (		rsician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or investigati	on, in my opinion, death occu				use(s)
Me	29b. Signature and title of certifier	Attending 1	2 Mysician 2	29c. License number	2	9d. Date sig	ned (Month, Day, Ye	ear)

H006111

E.

HagersTown

State Registrar Jum a Decello

FRANCISCO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 (

32. Registrar's Signature

Daniels

JH9+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:38 PM Rachel Elizabeth S. Snapkoski-Hall January 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Yrs. Director 251-10-7569 88 July 26, 1918 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location f show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15201 Elkridge Way 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2√2 No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Personnel Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas P. Shorter Camilla C. Ward ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Snapkoski/ Son 11 Ivy Hill Drive, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State xx Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Jano23, 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Dicenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End-Stage Cardiomyopathy /Medical Due to (or as a consequence of) Examiner <sub>b.</sub>Valvular Heart Disease Sequentially list conditions, Dissi to (or as a nonsequence of) if thy leading to him edit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the at d be detached for 4☐Pregnant at time of death 1 ☐ Yes 2 🗷 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 AOther (Specify) 1 ☐ Yes 2 ☐XNo ို 2 ER/Outpatient 3□ DOA Hospice 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred XXNatural 5 Pending investigation Injury after death.

I Director: Ald in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760 requires that the death certificate be at or Attending I Hospital

with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours at To the Funeral C 10

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29b. Signature and title of certifler Centher M Williams, DO

29c. License number H0058037

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia Williams, D.O. 6001 Muncaster Mill Road, Rockville, MD 20855

State Registrar 31. Date filed (Month, Day, Year) JAN 2 2 2007

29a. Certifier (Check only one)



Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD33383 Jan. 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Wilson, 1160 Varnum St., N.E. #021 Washington, D.C. 20017 M.D.Day, Year) N 2 2 gistrar's Signature 31. Date filed (Month 2007 JAN

State Registra

			For State Registrar	State of Ma		epartme Certifica					gienę Reg. Nd.	Z	03213
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Anne Belle Schul			41. 03				Januar			7:00P. M
	Examin	er	4a. Facility Name (If not institution, give s Renaissance Gardens (d	Riderwood Vi	.11age			Spri				County of Dea Prince (	George's
	Funeral Director		5. Social Security Number 6. Sex 288-07-4807	7. Age	(In yrs. last birti	rs. If Und Months	er 1 Year Days	If Under Hours	24 Hrs. 8	B. Date of Birth Month Day Feb. 13	, 191	9. Bir Oh	thplace (State or Foreign puntry) LO
	pug »		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
	Maryli	ō	Maryland Prince G		Silver		ζ						1 ☐ Yes 2 XNo
	or 28a	lrec	10e. Street and Number	<del>, _ <del>-</del></del>			ip Code				10g. Citi	zen of What Co	ountry?
	23a c	aiD	3160 Gracefield Ro			2	20904				Un	ited St	tates
036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mentall Hyglene. Depertment of Heath and Mentall Hyglene. Enter the maz I be marked other than "natural", or items 23a or 28a-f show eny Injury or other treumatic event, the Medical Examiner must be notified at page.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	ver in U.S.		<b>T7</b>	ispanic Ori in, Mexican Specify:		ify Yes or No- ican, etc.)		14. Race - Ame Black, Whit Specify:	
2 2	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a.	Decedent's Us	ual Occup	ation	at of working	7	16b. Ki	nd of Business	/Industry
121	vithin ne. han	mpidu	Elementary/Secondary (0-12)	College (1-4or 5+	) !	(Give kind of v life. DO NOT	use retired	1)		,			
2	filed v Hygle ther t int,	ပ္	17. Father's Name (First, Middle, Last)		HOIII	emaker		18. Mothe	er's Name /	First, Middle,		n home	
ylanc ould be fi	t Mental Mental Parked o	To Be	David Garber					Soph	ia Bl	um			
, Ma	end 2 st ealth and n 27 le n		19a. Informant's Name/Relationship (Ty, Alan Schultz -son	oe, Pnnt)	16	6 Resea	rch I	Road (	Green	belt, 1	Mary	r Town, State 1and 20	Zip Code) 0770
Baltimore, Maryland 21215-0036	Peges 1 nent of Hi ant: If iter ury or oth	i	20a. Method of Disposition  12 Burial 2 Cremation 3 □R  4 □Donation 5 □Other (Specify)	emoval from State	Beth A	r. crematory or	other place	tery	Da 1/21/			cation - City or ering,	
Balt	Depertit. Depertit Importit eny Inj		21. Signature of Funeral Service License	ngwad	P	Donale 4400 I	owde:	Borgw r Mil	ärdt 1 Roa	Funera d Belt	l Ho svil	me, PA le, Mar	cyland 20705
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line	he death. Do n	ot enter the m	ode of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		Todaming in dodain,	Due to (or as a		f):							
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Ö,	cate be executed by sician and the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	consequence	f);							
8760,	cate t physic	dica		-									
P.O. Box 6	The law requires that the death certificate be executed tie hes been signed by the attending physician and bage 2 should be deteched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-pronths? 1								livery Day Year		
مز	that the de ned by the a deteched f		Part II. Other significant conditions con	tributing to death but	not resulting in	the underlying	cause give	en in Part I		23e. Did to	bacco u	se contribute to	o the cause of death?
rds	w requires that been signed t should be det	d by								1 🗆 Y	es 2[	XNo 3□P	robably 4 Unknown
Division of Vital Records,	he law red e hes bee age 2 shot	Completed								24a. Was autop		prior to	utopsy findings available completion of cause of
ita	iclen: Th certificate rector, pag	4	25. Was case referred to medical				-	26. Place	of Death (	1 ☐ Yes Check only o		1 🗆 Yes	s 2□ No
<u>&gt;</u>	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2X No	lospital: 1  Inpatien		patient 3 🗆 🛭	Oth Oth	өг: 4 🗙 Nu	ursing Home	e 5 ☐ Resid	lence (	6 □Other (Spe	ecify)
ion	Attending Physiclen: r death. ector: After this certifice by the funeral director, p	ertification:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. T	ime of jury M	28c. Injun Work	yat k? Yes 2.□	28	3d. Describe h			
Divis	safter de safter de al Directo ed in by ti	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, facto	ory, office		28	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)  The Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of e and manner state	examination and	death occurre	d at the tin	ne, date an pinion, dea	nd place, an ath occurred	d due to the o	cause(s) date and	and manner at place, and due	s stated. e to the cause(s)
	Vithi To the	Σ	29b. Signature and title of certifier	00			9c. Licens				_	e signed (Mon	
	10		Lovem		mau			595			Jau	nuary	18,2007
		1	30. Name and address of person who co Loveen Puthumana,	mpleted cause of dea M.D. 3110	ath (Item 23a) ( Gracef	Type, Print) ield Ro	oad S	ilver	Spri	ng, Ma	ryla	and 2090	04
	Sta	ite ar	31. Date filed (Month, Day, Year)  JAN 2 2 200										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jan 3, 2007 Year 4:40ат м Peter Sakellaris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brookgrove Nursing Home Olney | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 223, 179329 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2□ F Greece 77 350-24-3704 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28a-f show the Medical Exercines must be notified at 1 Yes 2 ☐ No Director Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 United States 16309 Whitehaven Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Feb 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? Feb 195 1 lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 2 yes, 2 1 No Specify: Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ring most of working Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Business Owner Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fit iment of Health and Mental H tant: If Item 27 is marked ot Limberios Sakellaris Pangiota Michalopoolos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12521 Chiszar Dr, New Lenox, IL 60448 Larry Sakellaris/ Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cometery, crematory or other place)
Gate of Heaven Cem 50 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or ance. 1-6-07 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice see 22. Name and Address of Faguity seph Gawler's Sons, INC 5130 Wisconsin Ave, N.W. Washington, DC 20016 23a. Part1. Enter the drease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one is use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to increadate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit end resulting in death) Last Due to (or as a consequence of) physicien Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 5 Other (specify) signed by the et d be detached fo 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autonsy perfo certificete 1 Yes Attending Physician: director. To Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Sentifying Physician: To the best of my knowledge death occurred at the time, date and place and due to the daeso(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (D D42452 January 12,2007 Re kn 30. Name and address of person w/o mpl and cause of death (Item 23a) (Type, Print) Chitra Rajagopor 1811 Prince Philip Dr, #327, Olney, Maryland 20832 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend line 29d per phy aaco health dept 1/19/07 dlw State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Smith 2:17 2007 JUSEPL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center Medical Balhmore, 8. Date of Birth (Month, Day, Year)
July 7 19 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 17€ M 2□ F Months Days Hours 83 Yrs. Director 217-16-1195 1923 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at TX□Yes 2□No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 916 Wells Ave 21403 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Myes 2 □ No If Yes, Give 1 943 – 46 Year or Dates 1 943 – 46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Be Completed by 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Janitor V.A. Hospital 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve since. John Smith Mary Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Floyd(Daughter) 801 B & A Blvd. Severna Park, Md. 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 1-22-07 Crownsville, Md. \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Win Name Redese of Eacilisons Mortuary, P.A. Lavry H. Reese MOOS83 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the y ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Princienti Tumor months /Medical Due to (or as a consequence of) Examiner TLUTE Rend Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No this certificate 1 ☐ Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 018559 mp 01/12/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 10 N. Greene 32. Pégistrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 8 2007

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IRENE MARIE STRICKFADEN SCHWARTZ Physician JANUARY 19, 2007 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21212 CHESAPEAKE AVE. ROCK HALL KENT If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 F Director 281-05-4126 15,1915 OHIO Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Exeminer must be notified at Director 1 Yes 2 No MARYLAND KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 2. ang Ni Injury or other treumatic event, the Medical Examinar reserved. 21212 CHESAPEAKE AVE. 21661 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1. Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEO STRICKFADEN THERESA KRAMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY SCHWARTZ/ SON 5630 ROCK HARBOR DR. ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CNTR. 1/20/07 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN, NEWNAM FUNERAL HOME ROCK HALL Kuk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate MD. Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Artoro Sclovotic Cardio Vascular Disage **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certilicate be executed attending physicien and for use es the burial-translt that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HTD; Hypothyroid; Macular Dageneration Completed 1 Yes 2 No 3 Probably 4 Unknown 4 Chol: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2₽No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ fnpatient Other: 4 Nursing Home St Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturaf 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 750996 10 clle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leil Studdard 100 Mi Chestertan no 21620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:20PM 20 2007 ið Konal Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Hospital 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X**□M 2□F 579-86-8294 Feb. 24, 1959 47 **Director** Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 □Yes 2 □NO Directo Maryland Montgomery Montgomery Village 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 19417 Brassie Place, Apt. 103 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Fvarmina. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify Specify: White <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Allen Tull Margaret L. Murray ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Margaret L. Tull/ Mother 19417 Brassie Place, Apt. 103, Montgomery Village, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 24, 1 X Burial 2 ☐ Cremation 3 🙀 Removal from State Jan. George Washington Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2007 Plymouth Meeting, PA 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd, W., Silver Spring, MD 20901 RCORD 23a. Part. Enter the insease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or half failure in its only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metastatic months disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 1∐ Yes

s certificate has be irector, page 2 s To the Hospital or Attending Physician:

neral Director: within 24 hours a

To the Funeral C

completely filled i

Be ၉ Certification: Medical

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

600 N. Wolfe

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hopkins Hospital

State

Registrar DHMH 17 Rev 1/2001 Street

Kes - 000 Lei zheng,

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State
Registrar AMEND #19aperFH1/22/07; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day JAN. **Physician** Floyd 6:33 A M lõ, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Montgomery TAKOMA PARK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day,

Sepi. 24 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 □ F 1947 Mobile Alabama Hours 179-40-9130 Days Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 7 is marked other then "naturel", or iteme 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Prince Georges NEW CARROLLHOW Md. 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5526 KARENELAINE DRIVE U.S.A. 20784 Funerai Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces?
1 1 Yes 2 No
If Yes, Give Year or Dates: 1966 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then 'by injury or other treumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Supply Specialist US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon TAZEL APELLE CLARK ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5526 KAREN CLAINE DR. NEW CARROLLION, MD PAMELO TAZEL -wife 20a. Method of Disposition 01/18/2007 Cecil Two Pa, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NATI CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1125 Allegheny Avenue Julph Melums Pittsburgh, PA 15233 Sheffield Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Covency Antay disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence ol) Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 2 ER/Outpatient 3 □ DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation i Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 24 hours after To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) 52326 January 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Avenue James K. Lightfoot, M.D. Takoma Park, MD 20912 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 1TRH 24a, perVERB. G864, 2/2/07, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Cora Evelyn Wigfield January 0412 *27,* 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Elkton Elkton
If Under 1 Year | If Under 24 Hrs. Cecil 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, Year April 13, 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** 3, 1916 Maryland Months Days Hours Min 1 □ M 2 🔀 F 215-03-9249 90 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. The short of Hems 23a or 28a-f ehow ant: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow ury or other traumatic event, "Ire Medical Evancinar must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 √Yes 2 No MD Harford Director Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 163 Bloomsbury Avenue 21078 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Howard Mench ٥ Lillian Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda E. Vanorsdale (Daughter) 41 E. Bel Air Ave. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2X Cremation 3 □ Removal from State crtent: If \* 4 ☐ Donation 5 ☐ Other (Specify) 1/30/07 R. A. Ferris & Co. West Chester, PA permit. 22. Name and Address of Facility
Tarring—Cargo Funeral Home, P.
Aberdeen, Maryland 21001–3399 21. Signature of Funeral Service Licenses Depar Import 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician neemona /Medical Due to (or as a consequence of): **Examiner** ementia Imznow: Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. ng physician a Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ŏ Month Year Day 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown 3 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Division of Vital To the Hospitel or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 🗌 Yes 2 No 4 hours after death 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide C filled within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 0 eliders MD 00023322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 118 North St Scut 3B, ECKEN M) 21921 STACHDEN MO . 9

State Registrar 31. Date filed (Month, Day, Year) FEB 0 2 2007 32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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bel Box 6	death certificate be e attending physicie id for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom	2 Fetal	death 3 [	Ectopic pregna	ncy	,		23d. D	ate of delive	ry Day Year
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			30. Name and address of persop who co	mpleted cause of	death (Item	23a) (Type, I	Print)	, ,		17		1 '2,	700 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 9:00 PM 2007 Young Tanuan Leslie /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Medica -iViSta enter If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🏋 F Months Hours Yrs. July 28,1970 Maryland Director 212-027349 36 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 T¥Yes 2 □ No Director Bryantown Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5936 Roosevelt Place 20617 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic and 2 should be filed w ealth and Mental Hygie m 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) arvland Lester Sterns Phyllis Revnolds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If Item 27 I William Young/ Husband 5936 Roosevelt Pl Bryantown, Maryland 20617 altimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Injury or 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2007 Clinton, Maryland Resurrection 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd Aquasco, Maryland20608 23a Part1. Enter to: disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help it failure. List only the on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** ar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and I for use as the burial-transil Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) signed by the at 1 ☐ Yes P.0. 2 □ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1□ Yes 2☑ No ision or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and tine of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007

State Registrar Zafar

Road

Cucidorf MD

Post Office

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ansar!

31. Date filed (Month, Day, Year)

JAN 1 9 2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of I			iene	03222
	Physici	an	1. Decedent's Name (First, Middle, Last)		-			2. Date of Deal Month	Day Yea	
	/Medic	al		YOURTEE		4h City Town	or Location of De	JANUAR'	Y 22 200 4c. County of D	
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	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 24 H	s. 8. Date of Birth		Birthplace (State or Foreign Country)
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	land Dw		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
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21215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28e-f ehow ta Medical Erie", in er mail be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	vorking	16b. Kind of Busine	ss/Industry
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ylar	should be i and Mental   e marked o umatic eve	To E	GEORGE BRAGIN				HIRLEN	DA AVELA I	RITTER	
Maryland	and and le m		19a. Informant's Name/Relationship (Type					Rural Route Number		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importantis if item 27 le marked other then "natural; or items 23a or 28e-f show Importantis if item 27 le marked other then "natural; or items 23a or 28e-f show any injury or other traumatic event, if a Marical Eraci in at must be notified any once.		MICHAEL W. YOURTEE	20b.	Place of Dispo	sition (Name of	!	BROWNSVILI Date	LE MARYL/ 20c. Location - City	
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12	4-10		30. Name and address of person who co				D 1		-1 1 01:	71.0
	Sta	ite_	William F. Bodenh 31 Date filed (Month, Day, Year)	32. Registrar's Sign	ature	N	, Boons	ooro, Mary	yland 21.	/13
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Year OBER 4:30 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Howard Howard County General Hospital Columbia | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 20, 1920 Birthplace (State or Foreign Country) 5. Sociaf Security Number 7. Age (In yrs. last birthday) 1X M 2□ F 86 093-12-6307 Yrs. New York Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maine Hancock Surry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 04684 20 Abby Lane **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1941 If Yes, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Musician Free Lance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Hull Clyde Abernathy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Abby Lane Surry, Maine 04684 Doreen Abernathy, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/05/07 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility. Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Lespirator WEP Due to (or as a consequence of) neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetaf death 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Menonath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

**Physician** /Medical Examiner the attending physicien and hed for use as the burial-tran P.O. Box 68760 signed by the a Division of Vital Records, has I Diractor: After this d in by the funeral d death. after

Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours a To the Funeral C To the

**Physician** 

/Medical

Examiner

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Funeral

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Certification:

29a. Certifier (Check only one)

29b. Signature and title of certifie

**Funeral** 

Director

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permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic avant, once.

Baltimore, Maryland 21215-0036

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Registrar

GORIN 31. Date filed (Month, Day, Year)

**06** 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of reath (Ite 23a) (Type, Print)

32. Registrar's Signature

10724 Aparle

			For State Registrar	State of	Marylan			nt of H <i>te of L</i>				giene Reg. No.	007	03224
e.			Decedent's Name (First, Middle, L.)	.ast)							2. Date of Dea			3. Time of Death
	Physicia		Patricia A. An	derson							Feb. 1	, 2000	)7 Year	3:30 P M
T	/Medic Examin	_	4a. Facility Name (If not institution, g		oer)		4b. Cit	, Town, or	Location	of Death		4c. C	ounty of Death	1
	-Au	•	2606 Worrell Cr	t.			Cro	fton				Ar	ıne Arw	nde1
3 3- 4-	Funeral		Social Security Number     6.		. Age (In yrs.		If Und Months	or 1 Year Days	If Under	r 24 Hrs. Min.	8. Date of Birt	h v. Year)	Cou	place (State or Foreign intry)
	Director		578-64-1254	1 □ M 2 🗗 F	59	Yrs.	IVIOITEIL	Bujo	riouis	1411111	Apr. 2	, 194	7 Was	n. DC
	, nd		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						1	10d. Inside City Limits
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000	al", or	by	3 ☐ Widowed 4 ☐ Wivorced	If Yes, Give Year or Date			1 ∐ Yes	2X No	Specify	/:		5	Specify: Wh:	ite
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aud	oe file tal Hy doth	Be (	17. Father's Name (First, Middle, La.	st)							(First, Middle,		lurname)	
<u>8</u>	Men Men arke	၉	John W. Davis								Torril			
Mar	2 sh n and ls m raum		19a. Informant's Name/Relationship										Town, State, Z	
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14 4			23a. Part1. Enter the disease, or co shock, or heart failure. List on		used the deat	th. Do not ent	er the m	reder	CICK ig. such a	KOAO	BALLIIII r respiratory ar	rest.	Maryla	nd 21228 Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	ch line.									Interval Between Onset and Death
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36	d d ansit	Examin	Cause Disease or injury that initiated events											
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X Q Q	ath ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live bir	ome pf pregna th 2 ☐ Feta	al death 3		pregnancy	/			23	3d. Date of deli Month	very Day Year
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Ţ.	w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	Part II. Other significant conditions	s contributing to des	ath but not res	ulting in the u	nderlying	rause div	en in Part	t I	23e. Did to	obacco us	e contribute to	the cause of death?
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0	Phys raldi	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date of		28b. Time o		28c. Injur Wor	4 🗆 🗅		me 5 Residence 128d. Describe 1		Other (Spec	cify)
0	dIng h. Afte fune	tion	1 Natural 5 Pending 2 Accident investigat		n, Day Year)	Injury	М		k? Yes 2[					
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	To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this ce completely filled in by the funeral director.	-	29b. Signature and title of certifier	,								Zou. Date	signed (Monti	A - 24
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	8		30. Name and address of person wh	no completed cause	,		Print) Hasp	(b_1	16.5	0 0	rleans	Stra	+ ca	MD 21231
	Sta	ate	31. Date filed (Month, Day, Year)	9	gistrar's Sign		3/	, ,1		-		-11-68	-1 (1	U 104
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** М at 6 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner orest If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2XF Yrs. 24-603 Director Va1119 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 🔼 No **Funeral Director** re 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21050 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1□Yes 2/2(No Saltimore, Maryland 21215-0036 Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> 2504</u> MD21050 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 30 Evans runcial Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, in complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** tic 3 months sta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No IOV 24a. Was an autopsy performed? Yes 2 No this certificate 1∐ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident after death 6 ☐ Could not be within 24 hours after dear To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and altle of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD.

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

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Goods!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DON" /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore, M If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 17, **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 1 M 2 □ F 126-20-5545 78 Yrs. Director Newyork Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f sho other traumatic event, the Madical Examiner must be notified at Bel Air MD Harford **Funeral Director** 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Fox Bow Drive 21014 USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or ite 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married þ 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Newvork Transit Elementary/Secondary (0-12) College (1-4or 5+) Conductor Authority 10 17. Father's Name (First, Middle, Last)
Claude Bunn 18. Mother's Name (First, Middle, Maiden Sumame) Be Alice White ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Fox Bow Drive Bel Air, Maryland 21014 Gail P. Mullen- Daughter 20b. Place of Disposition (Name of cametery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Evans Funeral Chapel 2/9/2007 permit. Page Department of Important: If eny injury or once. Forest Hill, Maryland Si plure of Funeral Service Lice <sup>22. Name and Address of FEWans</sup> Funeral Chapel & Cremation Services
Bel Air 3 Newport Drive Forest Hill, MD 21050 23a. Part1. Enter the disease, or conshock, or heart failure. List only polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) 14001A **Physician** /Medical Examiner CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events SOONA Due to ( r as a cons y uence of). use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of) by Physician/Medical sate has been signed by the ettending, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 Yes 2 No Be 25. Was case referred to medical 28. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. I Director: Aff d in by the fur investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature an

J-SHIM

31. Date filed (Month, Day, Year)

title of certifier

FEB 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32/Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

29c. License number

PAUL PLACE

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

FEB 0 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Elvira Estelle Baylis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5239B Buttermilk Road Pylesville <u>Harford</u> 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F 130-16-4706 82 SEP 6, Director 1924 NY Usual Residence of Decedent buid be filed within 72 hours after death with tha Maryland Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Macified Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Harford Pylesville Pylesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5239 B Buttermilk Road 21132 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ **Plaschy** Pagas 1 and 2 should nent of Health and Men Anna Carlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once. If item 27 5239 Buttermilk Road, Pylesville, MD 21132
ce of Disposition (Name of 20c. Location - City or Town, State Donna Gosier - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2/3/2007 Baltimore, MD 21. Signature of Funeral Service Licensteven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Can minth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Il Records, P.O. Box 68760, 4 sician and burlal-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 7 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 🖾 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident Diractor: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sea Far you in Ď, 32, Registrar's Signature 31. Date filed (Manua Day Year) 200 State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 9:45 PM CHARLES 2007 BELL FEBRUARY 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLS TOWN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 1 M 2 □ F 214-56-3848 Aug 22, 1952 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Baltimore Randallstown MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Elm Cro 3807 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Mamied 1 ☐ Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Agriculture Secretar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bell Maggie Henderson Charles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Buttimore MD 21133 John Bel 3807 Elm Cruft 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Atbutus Arbutus, MD Feb 10, 2007 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rivally of Graycon Ferreral Service mdz 29 270 Fred Hilton Pass. Bally-mdz 29 Approximate 21. Signature of Funeral Service Licensee Ronald al 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury Due to (or as a consequence of): 101 Va that initiated events resulting in death) Last Due to (or as a consequence of): 3c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? □ Probably 4 □ Unknown

Physician /Medical Examiner

**Physician** 

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Examiner

**Funeral** 

Director

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Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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Physician/Medical þ Completed certificate Be Certification: To

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

		d
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23
	Part II. Other significant condition	ns con
П		

art II. Other sig	nificant conditions	contributing to dea	ath but not r	esulting in the	e underlying ca	use given in	Part I.

28a. Date of Injury (Month, Day Year)

	1 ∐ Yes	2 💹 NO	3
24a.	Was an autopsy		b. We

ere autopsy findings available or to completion of cause of ath? 2□ No

			26. Place of D
al: 1 Inpatient	2 ☐ ER/Outpatient	з∏ род	Other: 4 Nursing

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1□ Yes 2☑No 1 ☐ Yes eath (Check only one)

Other: 4 Nursing H	ome	5 Residence	6 □Other (Sp
Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how inj	ury occurred

_ rearoning re	01110		140110	- 0	
	28d.	Describe	how	injury	occurred
2 □ No					

28f. Location (Street and Number or Rural Route Number City or Town, State)

(Check only one)	2 Me

29b. Signature and title of certifier

27. Manner of Death 1 ☑ Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

25. Was case referred to medical examiner?

1 Yes 2 No

1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

28c. Injury a Work?

Name and address of pers	who completed cause of death (Item 23a) (Type Print)	

2,2007

١.	Name	and.	address	of pe	erson who	completed	cause	of death	(Item 23	3a)	(Type,	Р
1	200	. (	ama	-	-	tem	00	_	00	1	0	1
	101	11	7 1 4 ( )	$\mathcal{X}$	-1	- IV	7		-,0	- 1		14

Hospita

State Registrar 31. Date filed (Month, Day, Year) FEB 0 6 2007

5 Pending investigation

6 Could not be

determined



To the Funeral Director: completely filled in by the

Medical

within 24 hours a To the Funeral I the Hospita

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month  $\mathbf{P}^\mathsf{M}$ HNYKONY February 2007 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 212-48-830 1 M 2 ☐ F Director MAR Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b 10d. Inside City Limits 1 des 2 No Directo TIMORE TIMORE 10e. Street and Number 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be r 21206 Funeral ゼモハリビ 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: B/Aci Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Borner, Anthrone Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l and 2 should be fi. lealth and Mental H m 27 is marked oth Be MARY ART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ruel Route Number, City or Town, State, Zip Code) of Health 70 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 200 21. Sign in re of Funeral Service Licensee un, 23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause on ear ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending pl for use as t IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate has a la director, page 2 a autopsy perform 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes Inpatient Certification: To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Man ✓ of Death 1 ✓ Natural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred I or Attending F after death. 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital or within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, (ear) State 06 2007 Registrar

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_			1 - State Registrar					rtificate of			Reg. No.	10/	03232
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	/Medi	cal	Louis 4a. Facility Name (If not in		lward		Bennet	,		Flbrua		2007	10.35 A.M.
	Examir	ner	Baltimore W				enter	Glen B	or Location of Death	1		nty of Death	
	Funeral		5. Social Security Number	6. 8	Sex	7. Age (In yr.	s. last birthday)	If Under 1 Yea	r If Under 24 Hrs.		th	Aruno 9. Birth	IEL place (State or Foreign ntry)
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_	and		Usual Residence of Decer 10a. State 10b.	dent County		10c. 0	City, Town or Lo	ecation					0d. Inside City Limits
	Marylan n-f show	tor	MD Anı	ne Aru	inde1		n Burni						1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be fited within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. important: if Item 27 Is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	A				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
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111	fter d	Fun	1 Never Married 2	☐ Married	Armed Fo	orces? 21√1No	0.5.	Mas Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No p Rican, etc.)	- 14. H	ace - Americ ack, White,	etc.
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Division of Vital Records,	Hospitel or <b>Attending Physician:</b> The law requires that the death certificate be executed yt hours after death.  Funeral <b>Director:</b> After this certificate has been signed by the attending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ed b					<del></del> ,			1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
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State of Maryland / Department of Health and Mental Hygiene

Amend #1&5 Per Phy &FH G867 1. Decedent's Name (First, Middle, Last) Cornelia Elizabeth Lena Brewer 2. Date of Death Day **Physician** Month Year Cornelia Elizabeth Brower February 2007 2:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Friendship Hanover Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20,1914 5.247 Sec46 N3591 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Months Hours Min. 214-05-1388 92 Md. Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Iem 27 is marked other than "natural", or Iems 23s or 28s-1 show any Injury or other treumatic event, If a Mudical Examinar must be northflustered 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7548 Old Telegraph Road 21076 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lewis Jones ၉ Nellie Jane Titus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Betty McCullough/Daughter 212 Shipping Creek Drive Stevensville, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monocacy Cemetery Beallsville, MD 21. Signatu of Sugaral Samor Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1Second AVenue SW Glen Burnie, MD 21061 molled Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung Can Cer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Be Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attanding Physician: The law requires thet the death certificate be executed for use as the burial-transit the attending physicien end resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. To the Hospital or Attendity within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 504 200 MD who completed cause of death (Item 23a) (Type, Print) Pasadena, M 8109 SRIDITAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 7 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07:10 M FEBRUARY Brocato 2007 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner Anne ARYN DEL GEN Burnic Baltimore Wastlington Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 ☐ M 2X F 212-26-3303 76 April 12,1930 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 7 ie marked other than "neturel", or Items 23e or 28e-f ehow traumatic event, the Middical Exacultar traust be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Crain Highway Apt.307 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married land 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be.
Department of Health and Mental h.
Important: if I item 27 ie marken eny injury or other Be John Thompson Lillian Marie Homberg ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Charlene Coe/Daughter 864 Nabbs Creek Road Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 7, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Mol35 7 22. Name and Address of Facility Singleton Funeral Home, 1 Second Avenue SW Glen Burnie MD 21061 21. Signature of Funeral Service Licenses Marune rank R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) PNeumonia Physician /Medical Due to (or as a consequence of): Examiner Adeno charmony of the Lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physicien ander for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. | ed by the e signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≽</u> Records, Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1 Yes 25 No Division of Vital Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA ihis It 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: within 24 hours effer death.
To the Funeral Director: Afr 1XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the occurred; and viennar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Febru DD27415 4, 3, 2007 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henny Francis 301 Hospital Drive Glen Burnie, MD 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar FEB 06

DHMH 17 Rev 1/2001

Brocate,

ORIGINAL

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

**Director** 

To Be Completed by Physician/Medical Examiner attending | signed by the a d be detached f page 2: Director: After th Certification:

To the Hospital or Attending Physician; Te law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Ş	Maryland Montg	gomery	North	Potoma	ac				1 □Yes	2⊠No	
ire	10e. Street and Number		<u> </u>	10f. Zij	p Code		10g. Citiz	zen of What Co	ountry?		
aD	15533 Peach Le	af Lane			20878		Unit	ed Stat	tes		
ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13	.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Black						American Indian, White, etc.	
by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🛣 Divorced	rried 1 Tyes 2 1	10	1 □ Yes 2 ☒ No Specify: Spec							
To Be Completed by Funeral Directo	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	nt's Education est grade completed)  College (1-4or 5	+) (Gi	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Administrative Assistant  16b. Kind of Busines Department Transporta Highway Adm							
e C	17. Father's Name (First, Middle	, Last)	1		18. Mothe	er's Name (First, Middle			THOU FIGURE	OII	
.O.B	Arbie Eugene W	eems			Fran	ces Ellen	Pitts	Johnso	on		
	19a. Informant's Name/Relation	ship (Type. Print)	19b. Ma	iling Address	s (Street and Numb	er or Rural Route Numi	ber, City of	r Town, State,	Zip Code)		
	Carol B. Pate /	Daughter	1553	3 Peac	h Leaf La	ne, North	Potor	nac, Ma	rvland	2087	
	20a. Method of Disposition 1 ☐ Burial 2 M Cremation		20b. Place of Dis	position (Na rematory or	me of other place)	ebruary	20c. Lo	cation - City or	Town, State		
	4 Donation 5 Other (				orium, Inc			hesda,			
	21. Signature of Furieral Service Licensee  Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue, Bethesda, Maryland 20814										
	23a. Part 1 Enter the disease, of shock, or heart failure. Lis	or complications that caused	the death. Do not e	enter the mo	de of dying, such as	cardiac or respiratory	arrest,		Approxima Interval Be	tween	
	Immediate Cause (Final disease or condition		tage Deme	ntia					Onset and	Death	
	resulting in death)	Due to (or as	a consequence of):								
	Sequentially list conditions.	b									
jue	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):								
каш	that initiated events resulting in death) Last	C. Due to for an	a consequence of):								
画		Due to (or as	a consequence or,								
dic		d									
tification: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	etal death 3 Ectopic pregnancy					23d. Date of delivery Month Day Year		
F.	Part II. Other significant condit	tions contributing to death be	ut not resulting in the	underlying	cause given in Part I	. 23e. Did	tobacco u	se contribute to	the cause of	death?	
ed by	1 □ Yes 2√ No 3 □										
complet						24a. Wa: auto peri 1∐ Yes	s an opsy formed? 2 🖾 No	24b. Were as prior to death?	utopsy findings completion of c	available cause of	
ge C	25. Was case referred to medical examiner?	al			26. Place	of Death (Check only					
2	1 ☐ Yes 2 No	Hospital: 1   Inpatie				ursing Home 5 Res	idence 6	6 ∭Other (Spe	ecity)Hospi	ce	
tion:	27. Manner of Death 1 M Natural 5 □ Pendi 2 □ Accident invest	28a. Date of Inju ing (Month, Datigation	ry 28b. Time y Year) Injury	of / M	28c. Injury at Work? 1 ☐ Yes 2 ☐	28d. Describe					
tifice	3 Suicide 6 Could	I not be mined 28e. Place of inju- building, et	ury - At home, farm, : c. (Specify)	street, factor	y, office		(Street and	d Number or R	ural Route Nur	nber,	

within 24 hours aft

To the Funeral Di

completely filled in

Medical

State Registrar

29a. Certifier

Cynthia M.

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0058032

6001 Muncaster Mill Road, Rockville, Maryland 20855

and manner stated

Milliams

32. egistrar's Signature

D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

Williams.

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07-0	JU 7	90	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Richard Duncan I		1- For State	State of Mar	yland /		tment of		and N	/lental H		21	107	0303
Physicia Madical Evenin	n/	Registrar  1. Decedent's Name (First, Machard)	_		yrd,		Dog			2. Date of Dea	eg. No ith Day Yea		3. Time of Death
Medical Examin	ier	4a. Facility Name (if not insti	Duncan tution, give street an		yru,		4b. City, Tow	vn, or Loca	ation of Death	Month January 2	9, 2007		0540 hrs
		10504 Beachwood					Waldor				Charles		
Funeral Director		5. Social Security Number					If Under 1 Months	$\overline{}$	Under 24Hrs Hours Mir	_	rth (MM/DD/YYYY) 1/1958	Foreign	
		219-70-3412 Usual Residence of Deceder		F	48	Yrs				00/10	71330	Coun	Maryland
w any		10a. State 10b. Cou	*			own or Locat aldorf		_					Od Inside City Limits
yland n-f shov	햙	MD Ch	narles	l	W	aluori	10f. Zip Co				0- 0:5		1 Yes 2 X No
ith the Maryland 23a or 28a-f show any notified at once.	Director	10504 Beechw	ood Drive					601			0g. Citizen of Wh		y?
h with	ᇙ	11. Marital Status	12. Was	Decedent E	ver in U.S.		s Decedent	of Hispani		pecify Yes or No	14. Race	- America	n Indian, Black,
er deat	Funer	1 Never Married 2 3 Widowed 4	Divorced If Yes, Give	es 2 2	<b>(</b> No	If Yes, specify Cuban, Mexican, Puerto  Yes 2 X No specify:					White	Whi	+6
ours aft atural'	ē ģ	15. Decedent's Education (	or Dates:		oleted) 1	6a. Deceder	t's Usual Oc	cupation (	Give kind of		Specify: 16b. Kind of Bus		
36 n 72 ho nan "n: lical Ex	Completed	Elementary/Secondary (0-	-12) Colleç	ge (1-4 or 5	+)			•	NOT use ret	,	Country	, Cli	ıb
d within ygiene other the Med	Ē	17. Father's Name (First, Mic	ddle, Last)								Maiden Surname)		10
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	a	Richard Dun			rd, S				Eleano			dson	
	의	19a. Informant's Name/Relate Donna Windri		•							mber, City or Towr		(ip Code)
Te, N I and S Health Fitem S	1	20a. Method of Disposition				ace of Disposematory or ot	ition (Name	of cemete	ry,	Date	20c. Location -		own, State
altimore, mit. Pages I a ppartment of He pportant: If ite		1 Burial 2 X Crem. 4 Donation 5 Other	r Specify:		~ Hill	top Se	ervice				Towson,		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2		21. Signature of Funeral Ser	vice Elcensee Wi	lliam	G. Da		lame and Ad	Idress of F	acility Ru	ck Towso	n Funera	al Ho	me, Inc.
Physician	$\dashv$	23a. Part I. Enter the disease	e, or complications th	nat caused t	he death. D	o not enter t	ne mode of d	rk KC lying, such	as cardiac o	wson, MD or respiratory arr	21204 est, shock, or hea	rt	Approximate Interval
/Medical Examiner		failure. List only one ca Immediate Cause (Final dise	ease a. Smoke										Between Onset and Death
		or condition resulting in dea	.h) Due to (or b.	as a conse	quence of):						-		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca		as a conse	quence of):		_			<del></del>			-
d sit	Examin	(Disease or injury that initiat events resulting in death) L.	ed C.	as a conse	quence of):		-						
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60, ate be on the buria	Medical	IF FEMALE:	23c. If y	5a,27,2 /es, outcom	8a-f, j e of pregna	per ME,	g864, 2	2/7/07	TT		23d. Date of	delivery	
certificate nding physise as the	ian/	23b. Was decedent pregnant past 12 months?		ive birth regnant at t	ime of death	<u>, - =                                  </u>	tal death		ctopic pregna	ancy	Month	Day	y Year
Box e death c the atten	hysician/M	1 Yes 2 No 9	Hekeeum I	inknown		" 5	her (Specify	"			Ť		
ach the the	by P	Part II. Other significant co	nditions contributii	ng to death	but not resu	ulting in the u	inderlying ca	use given	in Part I.		obacco use contrit	_	e cause of death?
ds, equires	eted				_					24a. Was			osy findings available
ecor ne law i te has t	Completed										rmed? de	rior to con eath?	npletion of cause of
al R	Be	25. Was case referred to me examiner?			_		26.1		eath (Check	only one)	2 No 1	<b>✓</b> Yes	2 No
of Vital Records,  ng Physician: The law require the this certificate has been simeral director, page 2 should be	의	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatier		R/Outpatient		Othe			Residence 6		icene
On of ending Phath	tion	1 Natural 5	Pending Table	Date of Injury Month, Day,Ye	000-			Yes			how injury occurre		
Division tal or Attendii rs after death al Director: △	ertificati		ganon			unknown ne, farm, stree				28f. Location (\$	n of house		Route Number, City
Division of Vital Republic the Hospital or Attending Physician: hin 24 hours after death the Funeral Director: After this certifupletely filled in by the funeral director.	Sel	29a Codifier	determined (Spec		Home					waldori,	MD		vood Di.
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Medical	(Chesk only	g Physician: To the Examiner: On the ba	asis of exam									cause(s)
12.	Š	29b. Signature and title of of	and manr	ner stated.			29c. L	icense nui	mber		29d. Date signe	d (Month	, Day, Year)
65 and	(	Mul	rlen	)			С	D.C.M.E			January 29,	2007	
P		<ol><li>Name and address of pe Laron Locke MD.</li></ol>	rson who compl <del>eted</del> Assistant Med			<sup>3a)</sup> 111 Penn	Street, B	altimore	e, MD 212	201			
Sta Registi	ate	31. Date filed (Idonth, Day Y	6 2007	Registrar'		Loan						-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 30 per dyr 9864 2-6-07 yt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY Day, 2007 10:31 P M SAMUIL **BESSER** 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours UKRAINE 0472971918 216-39-5173 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 💢 No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6960 BROOKMILL ROAD #T-3 21215 UKRAINE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Mamied 1 ☐ Yes 2 X No WHITE Specify. Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER **EDUCATION** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BESSER DVOIRA ROSENFELD ISAAC 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIMITRIY BESSER / SON 2403 FOREST GREEN ROAD - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐ Removal from State HAR SINAI CEMETERY 02/04/2007 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Livensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG CANCER disease or condition resulting in death) Due to (or as a consequence of) RESPIRATORY FAILURE Due to (or se a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

**Physician** /Medical Examiner be executed use as the burial-tran and Division or Vital Records, P.O. Box 68760, attending physician cate has been signed by page 2 should be detact funeral director, After death. al or Attend after death. 24 hours a e Funeral I

Examiner Physician/Medical 2 Completed Be P Certification: Medical

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified it

Baltimore, Maryland 21215-0036

the Maryland

/Medical

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 1 X Natural 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

To the I within 24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Sherman

Northwest Hospital Center Randallstown, Md

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 6

32. Agistrar's Signature

Donald J. Camp	hall	Please Type or Print in Black Indelible Ink. Ensure All C		gible.	
Donaid J. Camp		State of Maryland / Department of Health and Ment  1-For State  Certificate of Death	ai Hygiene	200	7 02220
Physici		Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No. 💪 🗸 🔾	3. Time of Death
Medical Exami			Month February	Day Year	1131 hrs
and the co		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of		4c. County of Dea	ath
		Northwest Hospital Randallstown		Baltimore Co	ounty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		irth (MM/DD/YYYY) 9. E	
Director		220-36-9615 1xM 2 F 65 Yrs. Months Days Hours	Min. 02/1	16/1941 Fore	Country) MD
		Usual Residence of Decedent	1 02/3	10/1341	1110
v any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and f sho	5	MD Baltimore Woodlawn			1 Yes 2 XNo
Mary	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
h the	莒	3510 Milford Mill Road 21244		United	States
h wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original In Never Married 2 Married Armed Forces? 14. Marital Status 13. Was Decedent of Hispanic Original In Never Married 15. Marital Status 15. Was Decedent of Hispanic Original In Never Married 15. Was Decedent Ever in U.S. 16. Was Decedent of Hispanic Original In Never Married 16. Was Decedent Ever in U.S. 17. Was Decedent of Hispanic Original In Never Married 17. Was Decedent of Hispanic Original In Never Married 18. Was Decedent of Hispanic Original In Never Married 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Original In Never Married 19. Was Decedent Original In		o- 14. Race - Ame White, etc.	erican Indian, Black,
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hour hatu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		16b. Kind of Business	s/industry
36 nin 72 e. than cdical	흹	12 Longshoreman		Steamshi	p Trade
5-0036 led within 7 Hygiene. other than the Medica	ĕ	17. Father's Name (First, Middle, Last)  18. Mother's	s Name (First, Middle,	_1	PILOCO
215 e file tal Hy ked o	Be		cey John	son	
2121: buld be fi   Mental     marked   c event,	힏	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number 19b)	ber or Rural Route Nu	mber, City or Town, Sta	te, Zip Code)
MD d 2 shc lth and n 27 is		Cora Campbell-wife 5503 Channing R	Road Balt	imore, MI	21229
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City of	or Town, State
nor		1   XBurial 2   Cremation 3   Removal from State   crematory or other place)   4   Donation 5   Other Specify:   Crownsville VA Cem	2/9/07	Crownsvi	lle, MD
Baltimore, permit. Pages I an Department of Hee Important: If ite					
iii II Der 🥷		22. Name and Address of Facility 9200 Liberty	,wxtaat Rá	เกิดล์ไว้ระบ่ง	vn, mo ziii
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca failure. List only one cause on each line.	rdiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Death
Examine		or condition resulting in death)  Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions,			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Clience or initial but instituted			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physiciuneral director, page 2 should be detached for use as the bur	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic		23d Date of delive	· .
certil certil ending use as	ciar	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month	Day Year
Box death	·	1 Yes 2 No 9 Unknown 9 Unknown			
O.   at the dby ti	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I. 23e. Did t	obacco use contribute t	o the cause of death?
, P.O. res that the signed by	d by		1Ye	s 2 No 3 Pr	obably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should b	Completed		24a. Was auto		autopsy findings available completion of cause of
e law ie has ge 2 s	E D		perfe	ormed? death?	' _ I
l Re n: Th tifical or, pa		25. Was case referred to medical 26. Place of Death (0		2 No 1 V	Yes 2 No
/ita rsicia nis cer direct	o Be	examiner?	Nursing Home 5	Residence 6 Oth	er:
n of \ding Phy		27 Manner of Dogth		how injury occurred	
On on and ath arr. A he fur	Certification:	1 Natural 5 Pending (Month, Day, Year)	No		
Division tal or Attendii rs after death al Director: A	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	. 28f. Location (	Street and Number or F	Rural Route Number, City
Divital o	erti	4 Homicide determined (Specify)	or Town,	State)	4
Division of Vital Records, P.O. Box 68760, To the Hospital or Artending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check-entry)	ce, and due to the cau	se(s) and manner as sta	ated
o the ithin 2 or the mplet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated			
£ \$ £ 8	Me	29b Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)
		O.C.M.E.		February 4, 200	7
	14	30 Name and address   person who completed cause of death (Item 23a)			
10		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	tate				
Regis	trar	FEB 0 6 2007 Morece & January			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# / perFH C864 2 / 6 / 0 / WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** John Ralph Coleman 6:35 P M 3 2007 Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F 66 67/rs. 174-30-1594 Director Feb. 5 1939 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injortant: any injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Timonium Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 2209 Stryker Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ctor University Research

18. Mother's Name (First, Middle, Maiden Surname) Program Director 17. Father's Name (First, Middle, Last) Be Margaret Alice Lehn Ralph Eugene Coleman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Stryker Ct., Timonium, MD 21093 Sandra L. Coleman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/6/07 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Transitional Cell Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Year 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an ate has bade 2 s autopsy performed' this certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) age 18 lands AND Feb. 4, 2007 DOD61199

State

DHMH 17 Rev 1/2001

Registrar

, Suite 209, Towson, MD 21204

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

65 65 Marin Charles ST

Jason Black.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** COLEMAN JOHN ALBERT 02-02-2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE EASTPOINT REHAB AND NURSING CENTER DUNDALK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F JULY 25,1908 SC Director 98 213-07-0747 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ant; If item 27 is marked other than "natural", or Items be notified at ury or other traumatic event, the Mediael Examiner must be notified at BALTIMORE 1 Yes 2 No MD Directo EDGEMERE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 806 SPARROWS POINT ROAD
11. Marital Status
1 Never Married 2 Married
1 Never Married 2 Married 21219 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐ Yes 2 XNo f Yes, Give Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETH STEEL STEELWORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNIE BROWN ပ CHARLES COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 DAMSEL ROAD, ESSEX, MD 21221 19a. Informant's Name/Relationship (Type. Print) CALVIN STATHAM/BROTHER IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM PK 02/08/07 BALTIMORE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature di Funeral Service Licensee 1701 LAURENS STREET, BALTO., MD 21217 23a. Part F Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bleec CTUSTO INTESTINU **Physician** Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 TYes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kernet C. Dout February Le, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Baltimore, MD Kubert Dart 901 Furt E 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 6 Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 1:30 P. Dawson Cavey 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year) Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday if Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Days 76 Hours Director 219-28-4587 VA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10d. Inside City Limits Director Glen Burnie 1 ☐ Yes 2 No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Crain Highway Apt.114 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Jane Chrisopher McLaurin C. Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence J. Cavey Jr. /Husband 7975 Crain Highway Apt 114 Glen Burnie MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 5, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 2007 Baltimore, MD 22. Name and Address of Facility Singleton Funeral Home, 21. Signature of Funeral Service Licensee 1 Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE if yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate hes al director, page 2 autopsy 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: 1 ☐ Yes Inpatient Other: ဥ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Magner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my policing doubt. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar Name and add

Print)

ress of person who completed cause of death (Item 23a) (Type

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** žö, 11:20A M January Nellie May Calantonio \*/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🕅 F Months Days Hours 1915 Maryland Director 219-88-1034 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumattc event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1√100 2 No Funeral Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? United States 20850 909 Allan Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Tyes 2 No Specify Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Stenographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Hannah Leahy ၉ John W. Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 911 Allan Road, Rockville, Maryland 20850 Michael Calantonio/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial 20c. Location - City or Town, State 20a. Method of Disposition February Parklawn Me Park Burial 2 ☐ Cremation 3 ☐ Removal from State 3, 2007 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signalia neral Service Lice M00803 Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 weeks umon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. John, g. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy page performed death?
1 ☐ Yes 2 No 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mann - Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t (Month, Day Hospital or Attending 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral D 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20852-3142 11125 Rockville Pike, #208, Rockville, Maryland Aruna S. Nathan, M.D

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 2007 11:45PM William Campas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 6336 Cedar Lane Columbia If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Jan. 14, Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Year. 86 1921 067-22-2110 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21044 U.S.A. 6336 Cedar Lane Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> Specify: White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor of Engineering Howard Community College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Comnenos James Campas ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9422 Glen Ridge Drive Laurel, MD 20723 Mary Glaros (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gates of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 2-6-2007 Silver Springs, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Witzke Funeral Homes, 4 Hackm 5555 Twin Knolls Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ulmonora 4 eac /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usesase or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Hospital or Attending Physician: after death. hin 24 hours a the within To the ို

Registrar

Medical

State

29a. Certifier

(Check only

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

1105K Little Patrick Pkins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 204

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 06 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician Robert C. Chilcote February <u>10:</u>30a <sup>M</sup> 2007 "/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson
nder 1 Year | If Under 24 Hrs. Greater Baltimore Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 177 M 2 □ F Yrs Dec. 15,1942 64 Director 212-48-5254 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho MDBaltimore 1 ☐ Yes 2 No Director Perry Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8427 Old Harford Road Apt. C USA 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify Specify: White δ 3 Widowed 4 Divorced Maryland 21215-003 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Rec. & Park Supervisor marked other or other traumatic event, Jih and Mental Hwarts Is mark 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard C. Chilcote Margaret E. Eisenhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a: If item 27 is Michele Chilcote- Daughter 16 Birsay Court Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or 2/6/07 Moreland Cemetery Baltimore, MD 21. Signature of Funeral prvice Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 1409 6415 Belair Road Baltimore, MD 21206 23a. Part Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorrhagic **Physician** 5 days STrok E /Medical Due to (or as a consequence of) **Examiner** Hypertension Uncontrolled Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, P.0. Division or Vital Records,

al or Attending Paffer death.
I Director: Affer id in by the funers After e Hospital 24 hours a e Funeral I

1241

DHMH 17 Rev 1/2001

State Registrar

Medical

Karen m. Piper 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 ☐ Could not be

250

mo

<del>2007</del>

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N Charles St Suite 5218

and manner stated.

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DU 47223

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

02-02-2007

Baltimore mo 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Alda Baptiste Castaldi 8:48 p. January 30, 2007 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 □ M Director 032-01-4729 January 6, 1918 Massachusettes Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21043 U.S.A. 8060 Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specity. Specity: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specity only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Gown & Dress Fashions **Business Owner** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Palmeda Travers Francisco Baptiste ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8016Brightlight Place Ellicott City, Maryland 21043 Mr. James Castaldi Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 DCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specity) Important: If it any injury or o once. 02/05/07 Baltimore, MD **Bayview Crematory** 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician + /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit Exami Due to (or as a consequence of) Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 2 No been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No JA: 24a. Was an has autopsy performed certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA ၉ After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F s after death. Il Director: After d in by the funera (Month, Day Year) 1-Natural 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

certificate be executed P.0. or Vital Records, Division

and

altimore, Mary

To the Hospital of within 24 hours at To the Funeral E

State Registrar

31.	Date	filed	(Month,	Day,	Year)	
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29b. Signature and title of certifie

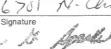
29a. Certifier

Medical

32. Registrar's Signature FEB 0 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



29c. License number

harles St. Balts. md

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / Department of Health and Mental Hygiene  1- State Registrer  Certificate of Death  Reg. No. 2   7   0   3   2   5
	Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 2 3 6 7 4 3 6 M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)  MERCY MEDICAL CENTER  4b. City, Town, or Location of Death  4c. County of Death
	Funeral Director		5. Social Security Number  6. Sex  1 M 2X F  7. Age (In yrs. last birthday)  1 M 0nths Days Hours Min.  7. Age (In yrs. last birthday)  Months Days Hours Min.  7. Age (In yrs. last birthday)  Months Days Hours Min.  7. Age (In yrs. last birthday)  Yrs.  7. Age (In yrs. last birthday)  NC
	and wo		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits
	e Mary	ctor	MD NA Baltimore X <sup>□ Yes 2 □ No</sup>
	with the a or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	death	Funerai	103 La Rve Sq. 21225 U.S.A.  11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural," or Items 23a or 28a-1 show other traumatic event, If a Medical Exercitation in the notified at	by	1 Never Married 2 Married 1 Yes, Give Year or Dates:  1 Yes 2 No Specify: Specify: Black
15-0	n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
212	e filed within al Hygiene. I other than "	Comp	Elementary/Secondary (0-12) 12th grade  College (1-4or5+) na  Supervisor  U.S. Soldier's Home
Maryland 21215-0036	d be filed antal Hygic ted other c event, L	Be	17. Father's Name (First, Middle, Last)  Willie Newsome  Hattie Watson
aryl	2 should be and Mental is marked o	To.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health a lem 27 is		Clentis Barnes-Daughter 103 La Rve Sq., Baltimore, Md 21225  20a. Method of Disposition (Name of Date 20c. Location - City or Town, State
mor	Pages ent of H nt: If ite ry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Garrison Forest Vet. 2/12/07 Owings Mills, Md
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. The lure of Funeral Service Licensee  22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate
	Pnysician /Medical		ise e or condition a. ATHEROSCLEROTIC HEARI V) 13 8 7438
	Examiner		Due to (or as a consequence of):  Sequentially list conditions,  b.
	nsit A	Examiner	cause. Enter Underlying Cause (Disease or injury
ó	ficate be executed physician and is the burial-transit		that initiated events resulting in death) Last Due to (or as a consequence of):
68760,	physics physics the bu	edical	d
O. Box (	death certi e attending nd for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)
ds, P.	es be	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Vital Record	e taw has b	ompieted	STZOKE  24a. Was an autopsy findings available prior to completion of cause of death?  1□ Yes 2□ No  1□ Yes 2□ No
/ital	icien: Th certificate rector, pag	Bec	25. Was case referred to medical an examiner?
of	Phys ral dii	): To	Hospital: 1 Inpatient 2 Beoutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
sion	ending leath. or: After he funer	atio	Total tural   5   Pending   (Month, Day Year)   Injury   Work?
Division	tel or Attendi s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	tosph thour uner	Medicai C	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
1	To the P within 24 To the F complete	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. 20d. 20d. 20d. 20d. 20d. 20d. 20d. 20
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KEUIN O. BABB, MD 301 ST PAUL PLACE, BALT MD 21202
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature
	Regist	ar	FEB 0 6 2007   10000 15 10000

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 5, 2007 **Physician** Lance Bowen Duker 11:00 A M /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carney 3005 Sixth Ave. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 21, 1953 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 213-60-5054 1 M M 2 □ F 53 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medi-al Examiner must be notified at 1 ☐ Yes 2 No Carney Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 21234 10e. Street and Number 3005 Sixth Ave. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify hite Specify: 9 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AAI College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Machinist N/Ă 12 18. Mother's Name (First, Middle, Maiden Surname) Margaret Melissa Clements 17. Father's Name (First, Middle, Last) Be William John Duker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Bigmount Court Abingdon, MD 21009 19a, Informant's Name/Relationship (Type, Print) Mrs. Melissa East- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/8/2007 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill, Maryland Department of Important: If any injury or once. Evans Funeral Chapel 4 Donation 5 DOther (Specify) 21. Signal VI Funera B. Ni Licens e 22. Name and Address of Franceful Alternatives Funeral Communition Cir. P.A. 2325 York Rd. Timonium, Maryland 21093 YAR 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of) ivision or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Tes Medical Certification: To this 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the Hospital or Attending Physician: within 24 hours at To the Funeral Completely filled i

> J State Registrar

GEORGE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARKAN

29c. License number

016189

eath (Item 23a) (Type, Print) Charles St A 615 TOWS ON MD 2/20

29d. Date signed (Month, Day, Year)

2/6/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Mae 2007 rebeval /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NIA Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Hours Months Days 1 ☐ M 2 🕱 🗷 NC 67 Yrs. 214.40.2347 03.13.1930 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 ☐ No Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 East Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Mamied 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housekeeper 7th ara de 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Campbell David Hines 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23rd Street East Baltmore MD onaleta Foster Grand Daughter 137 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Cometen 02.08.07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee of Facility reene Funeral Services Road Baltimore MD YOUL\_ Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WE Immediate Cause (Final tast Physician 0 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe /es 2 2 1∏ Yes Division or Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient Medical Certification: To 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manger of Death (Month, Day Year) Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month.-Day, Year)

State Registrar

3

30. Name and addres

31. Date filed (Month, Day, Yea)

FEB

06

2007

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:15 P Feb. 4 2007 Albert /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville College Manor Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) Social Security Number 6. Sex Year, **Funeral** Min. 1∏ M 2□ F Months Days Hours 14 1930 76 Director 212-26-7017 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Lutherville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 21093 2006 Eastridge Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2√2 No white Baltimore, Maryland 21215-0036 Specify: ð 3 Widowed 4 □ Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Isabelle Ward Iver Gilbert Dorsch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 198 Ferring Ct., Abingdon, MD 21009 Elizabeth Congdon/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/8/07 X Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial Gardens | Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Inc. Michael J Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of) resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year Day in the past 12 months? ☐Yes 2☐No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 robably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate b 1∐ Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 25 No 1 | Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28b. Time of 28c. Injury at Work? 27. Maryler of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760

State

DHMH 17 Rev 1/2001

completely filled

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Todd

Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baldanza,

29d. Date signed (Month, Day, Year)

10753 Falls Rd, Suite 225, Pavilion 2, Lutherville, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lan Mathew D		1- For State Registrar	Maryland / Depa Ce	rtificate of		Mental H		g. No. 2 1 1	7 0225	
Physici ledical Exami		1. Decedent's Name (First, Middle,Last) Alan M. Doxzon					Date of Death     Month     February 1	Day Year	3: Time of Death U	
.a		4a. Facility Name (if not institution, give str	eet and number)	4	b. City, Town, or L	ocation of Death	_	4c. County of Deat		
		713 Gunsmoke Trail	1=		Lusby	Two cas	To be a special	Calvert		
Funeral Director		5. Social Security Number 6. Sex 181-60-5643	7. Age (In yrs. 2	38 Yrs.	If Under 1 Year Months Days	If Under 24Hrs Hours Min	-	er 5,1968 cc		
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location	on				10d Inside City Limits	
A .	_	Maryland Calvert		Lusby					1 Yes 2 X No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	•		10f. Zip Code	. ===	10	g. Citizen of What Cou	•	
ith the 23a or notifie		713 Gunsmoke Trail  11 Marital Status 12	. Was Decedent Ever in U	LC 142 Wes	20657 Decedent of Hisp	ania Óulnino / Ba	asti Vas as Na	United S		
eath w	Funeral	1 Never Married 2 X Married	Armed Forces?  Yes 2 X No		s, specify Cuban,			White, etc	rican Indian, 8lack,	
after d	by Fi		es, Give Year Dates:		Yes 2 X No				hite	
2 hours "natur	ted	15. Decedent's Education (Specify only h  Elementary/Secondary (0-12)	ighest grade completed) College (1-4 or 5+)		s Usual Occupation st of working life. I			16b. Kind of Business	/Industry	
5-0036 iled within 72 Hygiene. I other than "	Completed	12		d/disabi	Led	n/a	n/a			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Are a Tris marked other than "natural", or items 23a or 28a-f 5the matic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) Elmer M. Doxzon			1		(First, Middle, M	laiden Surname)		
212 ould be Menta marke	To Be	19a. Informant's Name/Relationship (Type,	Print )	19b. Mailing	Address (Street			ber, City or Town, State	e, Zip Code)	
MD of 2 sho ulth and m 27 is aumati		Kathleen Doxzon/wif			ınsmoke I		Lusby, N			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Heatly and Mental Hygene. Important: If iten 27 is marked other It injury or other traumatic event, the Med		20a. Method of Disposition  1 Burial 2 X Cremation 3 1	Removal from State	crematory or oth			Date	20c. Location - City o		
Itim iit. Pag artment ortant: ry or o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee			rematory		5,2007	Camden, N	ew Jersey	
Depti		John O. Mitchell	TIX-		Mitche 6506 Y	11-Wiede	efeld Fu Balti	neral Home more, MD	1nc. 21212	
Physician /Medical		23a. I. Enter the disease, or complicate liure. List only one cause on each I	ine.		e mode of dying, s	such as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
Examiner			nbined oxycodon to (or as a consequence		ohol intoxi	ication			Death	
	Ļ	Sequentially list conditions, b	to (or as a consequence	-6\-						
	miner	C. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
uted d ansit										
, be exect cian an irial - tr	Medical									
cox 68760, eath certificate be executed attending physician and for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	gnancy	aldeath 3	Ectopic pregna	ancv	23d. Date of delive	ry Day Year	
Box 687 death certific he attending p	icia	past 12 months?  1 Yes 2 No 9 Unknown	Pregnant at time of d	looth	ner (Specify)		aricy	World	Day Teal	
<b>0</b> 7	Physician/	Part II. Other significant conditions con	Unknown	resulting in the u	nderlying cause g	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
;, P.O. ires that the signed by t	d by				, , ,				obably 4 🗹 Unknown	
Division of Vital Records, rat or Attending Physician: The law requirer as after death al Director. After this certificate has been sifed in by the fineral director, page 2 should bed in by the fineral director, page 2 should be a present and pre	Completed						24a. Was a		utopsy findings available completion of cause of	
Reco The law icate has	l mo						perfor 1 Yes 2		es 2 No	
ital Recician: The scertificate rector, page	B B	25. Was case referred to medical examiner?	oital: 1 Inpatient 2	ER/Outpatient		of Death (Check		Posidones 6 d other		
n of Vit ling Physic After this funeral dire	1: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I		y at Work?		Residence 6 0 the	er. Scene	
ion ttendir death ttor: A	ation	1 Natural 5 Pending 2 Accident Investigation	Fnd 2/1/2007	unk.	1 Y	es 2 X No	unk.			
Divising pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 X Could not be determined	28e. Place of Injury - At I		t, factory, office bu	uilding, etc.	or Town, S	<sup>tate)</sup> 713 Gunsm	ural Route Number, City oke Trail	
Ele Se Poi		4 Homicide	(Specify) Hom To the best of my knowle		red at the time, da	te and place, and	Lusby, Midue to the caus		ited.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: Or an	the basis of examination d manner stated.	and/or investigat			at the time, date a			
	Σ	29b. Signature and title of certifier		<del></del>	29c. License O.C.N			29d. Date signed (Miles February 2, 200		
		30. Name and address of person who com	pleted cause of death / Ite	m 23a)	0.0.1	n. L.		i Gordary 2, 200		
		Laron Locke MD. Assistan	t Medical Examiner	111 Penn	Street, Baltim	nore, MD 212	201			
Regi:	State		32. Remar's Signa	ture	and I					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State o	f Maryland		artment of H ctificate of I		•	giene Reg. No. 2	0.7	02252	
Е			1. Decedent's Name (First, Middle, Last)	<u> </u>				2. Date of Dea	ath	Year	3. Time of Death	
Ás.	Physicia /Medic		Robert Dupree					02	02 2	007	6:30 P <sup>M</sup>	
À	Examin	er	4a. Facility Name (If not institution, give street and nu Futurecare – Honewood	mber)		4b. City, Town, or	Location of Death	٦	4c. County of Death			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	Baltimore If Under 24 Hrs.	8. Date of Birt	h (Yoar)	9. Birthpla	ace (State or Foreign	
	Director			- 6	2 Yrs.	Months Days	Hours Min.	07/27/19		Count	SC	
	land bw It		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	d. Inside City Limits	
	a-f sh ified a	ctor	MD			Baltir	nore				1 Yes 2 No	
	or 28	Director	10e. Street and Number 4507 Fairview Avenue			10f. Zip Code	01.01.6		10g. Citizen of W		ry?	
	eath v	Funeral		edent Ever in U.S	S. 13. V	Was Decedent of H	21216 ispanic Origin? (S	pecify Yes or No	US. - 14. Race	- America	ın Indian,	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	by	Armed F.  1 Never Married 2 Married 1 Fyes, G. 3 Widowed 4 Divorced Year or D.	orces? 21 No ve		Was Decedent of H f Yes, specify Cuba l □ Yes 2፟ No	an, Mexican, Puèri Specify:	o Rićan, etc.)	Black Specify:	Afric Ameri	an ican	
21215-0036	72 hc "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	ient's Usual Occup kind of work done	during most of wor	rking	16b. Kind of Bu	siness/Ind	ustry	
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	e filed Il Hygi other /ent, tl	Be C	17. Father's Name (First, Middle, Last)			110112		ne (First, Middle,	Maiden Surname			
ylar	2 should be and Mental is marked o raumatic eve	To B	Robert Dupres	2				Rosa T	Chomas			
, Maryland	1 and 2 sho Health and em 27 is m		19a. Informant's Name/Relationship (Type. Print)  Mone Dupree			ng Address (Street Fairview A				State, Zip 1216	Code)	
Baltimore,	permit. Pages 1 am Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from	StateCe	emetery, crer	sition (Name of matory or other place		Date	20c. Location -	•		
<u>=</u>	it. Pa Intmen Intant:		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service □ censee	Met	ro Crem	atory 2. Name and Addre		6/2007	Baltimore			
Ba	permi Depar Impo any Ir once.		21. Signature of Furieral districts	2	-		n Gilmor St		Funeral H timore. Ma			
			23a Part1. Enter the disease or complications that shock, or heart failure. List only one cause on	caused the death	. Do not ent						Approximate Interval Between	
5	Physician	i	Immediate Cause (Final disease or condition resulting in death)	rogres	we	per the mode of dyir	u				Onset and Death	
	/Medical Examiner		Due to	(or as Consequ	ence of):	- 0	16	4	./-			
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	acuted nd transit	Examiner	in any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	m	Hod	ghn 1	magney	ma				
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ŏ	th certi ending r use a	an/M	230. Was decedent pregnant	itcome pf pregnai birth 2 🗆 Fetal	ncy death 3F	Ectopic pregnancy	,			e of delive	,	
P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nant at time of de	eath 5	Other (specify)		Month			Day Year	
	that the	y Ph	Part II. Other significant conditions contributing to o	leath but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contr	ibute to the	e cause of death?	
rds	w requires been sign should be		Damentre					1 🗆	Yes 2□ No	3 ☐ Proba	ably 4 Onknown	
eco	e law requ has been ye 2 shouli	Completed						24a. Was	an 24b. V	Vere autop	osy findings available inpletion of cause of	
<u>등</u>	: The cate h , page	Con							rmed?	eath?	2 □ No	
Zit Zit	siclan certifi irector	Be C	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1	Inpatient 2 □ E	ED/Outpotion	ot 3 DOA Oth	-	ath (Check only o				
0	Attending Physiclan: r death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date		28b. Time o	IL 3 DOA	4 Lanursing i		dence 6 Other		)	
Sior	endin ath. or: Aft	atio	2 Accident investigation	ilit, Duy Toury	піјагу		Yes 2 □ No					
Division or Vital Records,	al or Att s after de al Direct	Certification:	determined 200. Flat	e of injury - At ho ling, etc. (Specify	me, farm, str	reet, factory, office		28f. Location ( City or To	Street and Numbe wn, State)	er or Rural	Route Number,	
	To the Hospital or Attending Physiclan: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  1 CertifyIng Physician: To the 2 Medical Examiner: On the and ma	e best of my know basis of examinat nner stated.	wledge, deat tion and/or in	h occurred at the till vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)	
	To the Vithing Comp	M	29b. Signature and title of certifier	My	)	29c. Licens	31467	,	29d. Date signed	Month, L	Jay, Year)	
	1		30. Name and address of person who completed cau	se of death (Item	23a) (Type,	Print)	C+ C	+ 215	211-	1.000	0 - 0 - 1)	
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	Sta Regist		FEB 0 6 2007	egistrar's Signal	K &	2000						

Registrar
DHMH 17 Rev 1/2001

		í	1 - For State Registrar	State of M	Maryland / Dep		nt of H	lealth a	and M	lental Hyg		007	03253
	Physici	an	Decedent's Name (First, Middle, Las.							2. Date of Deat Month		Year	3. Time of Death
	/Medio	cal	Hiram Dicaro							2	3	2007	1:54 AM
	Examir	ner	4a. Facility Name (If not institution, give				Town, or	Location	of Death		N/A	ounty of Death	
	Funeral		5. Social Security Number 6. Se	x 7.	Age (In yrs. last birthda)	) If Under	r 1 Year	If Under		8. Date of Birth		9. Birtho	lace (State or Foreign
	Director		214-38-4698	XM 2□F	66 Yrs.	Months	Days	Hours	Min.	May 21,	1940	North	Carolina
7	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation						1	0d. Inside City Limits
1	1 sho	ō	MD N/A		Balti								1 ☐ Yes 2 ☐ No
4	r 28a	rec	10e. Street and Number				o Code			10	0g. Citize	n of What Cour	itry?
4	23a o	aiD	4614 Shamrock Ave	nue				212	.06		USA		
36	be filed within 72 hours after death with the maryland tall Hygiene. All Hygiene. All the Maryland Esta pher must be notified at event, the Maryland Esta pher must be notified at	y Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force 1 24 Yes 2 [ If Yes, Give Year or Date:	□No	. Was Dece If Yes, spe 1  Yes				ecity Yes or No- Rican, etc.)		Race - Americ Black, White, pecify: Wh11	etc.
S I	atura Cul E	Completed by	15. Decedent's Ed	ucation	16a. Dec	edent's Usu	al Occupa	ation	- 77.1		16b. Kind	of Business/Inc	dustry
215	and and and and and and and and and and	ple	(Specify only highest grad	de completed) College (1-4d	)r5+)	e kind of wo DO NOT u		during mos l)	t of work	ing			·
21	ygien her th				Me	chani	С					et Metal	<u> </u>
Maryland 21215-0036	a z snould be lited within h and Mental Hygiene. 7 is markad other than traumatic event, it s M.	To Be	17. Father's Name (First, Middle, Last) Angelo DiCara							Woody	Maiden Su	umame)	
lan.	permit. Pages 1 and 2 should Department of Heatth and Men Important: if item 27 is marka any injury or other traumatic <u>once.</u>		19a. Informant's Name/Relationship (7							al Route Number,			Code)
6,	permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr once.		Charlotte DiCara- 20a. Method of Disposition	Wife	20b. Place of Dis			Aven		altimore			Charles Charles
Jo	ages nt of h		1 ☐ Burial 2 🖾 Cremation 3 🗋		te cemetery, cr	ematory or o	other plac					tion - City or To	
Baltimore,	artme ortani Injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service License</li> </ul>		Metro Cr	emato	rv_	s of Facilit	2/5/	07 1	alti	more, N	(D
B	limp y de p		1 How			415 B	elar	r Roa	d Ka	ler-Dipp	MD MD	uneral	Home
			23a. Pa 11 I nter the dise se, or composhock, or heart the List only	lications that cous	ed the death. Do not e							21200	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition			Disa	-0						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	ary Arteruas a consequence of):	21360	.,,						
	- Adminier	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):								
3	ned in sec	Examiner	Cause (Disease or injury	Due 10 (01 a	as a consequence or).								
ć	exection and ital-tra	Exa	that initiated events resulting in death) Last	C. Due to (or a	as a consequence of):								
68760,	cate be executed physician and the burial-transit.	icai		d									
89 )	Priystotan: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit		IF FEMALE:								_	- 121	
Вох	death cerrific attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic p					230	d. Date of delive Month	ny Day Year
P.O.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐Unknown		Other (s	овсту)						
٥	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in the	undertying o	ause give	en in Part I		23e. Did tob	acco use	contribute to th	e cause of death?
Records,	quires no sign	q pe	Chronic Obstructi	ve Pulma	nary Disease					1 <b>P</b> Ye	s 2 🗆 1	No 3□Prob	abiy 4 □Unknown
000	aw requir	plet	Stroke		J					24a. Was ar		24b. Were auto	osy findings available
E E	sician: The faw s certificate has t lirector, page 2 s	Completed	Hypertension						Polit-Bilderore	autops perform	ned? _	death?	πpletion of cause of 2□ No
Vital	ertific ector,	Be (	25. Was case referred to medical examiner?				-		of Deati	Check only one			
of \	this c	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Nnpa				4 🗆 140	-	me 5 Reside			<i>'</i> )
nc	ding Pnysician: h. After this certific funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir (Month, I	njury 28b. Time Day Year) Injury	of 2	28c. Injury Work	/at <br Yes 2□		28d. Describe ho	w injury c	occurred	
Division	deatl deatl ctor: y the	fica	2 Accident investigation 3 Suicide 6 Could not be determined	280. Place of	Injury - At home, farm, s			163 2	-	28f. Location (Str	eet and f	Number or Rura	I Route Number
S.	s effer i Dire	erti	4 Homicide	building,	etc."(Specify)		,,			City or Town			,
	to the hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the be iner: On the basis and manner	st of my knowledge, des of examination and/or stated.	ith occurred nvestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ca red at the time, da	use(s) ar ite and pl	nd manner as st ace, and due to	ated. the cause(s)
1	within To the	Me	29b. Signature and title of certifier			29	c. License	e number		29	d. Date s	signed (Month,	Day, Year)
)			Idam B. Ed	-ands	-, MD		P2	1186	•		2/	3/200-	7
2	XI		30. Name and address of person who o	ompleted cause o	f death (Item 23a) (Type			•					
)			Adam B. Edward	and the second second	S. Greene S			timore	e, M	D 2120	1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 6 2	32. <b>3</b> 9i	strar's Signature	And Stand	ō						
	- logist	- LI	red U 0 2	JU! Later	THE JO JE	A Paris							

# Pages 1 and 2 should be filed within 72 hours after death with the Maryland とろれて al Hygiene. Baltimore, Maryland h and Mental F is marked of item 27 the death certificate be executed Box 68760. nding physician atten for P.0. Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ,050M Dorothu Elizabeth Feiler 300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Square Baltimore OSECIALE HOSDITA 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, **Funeral** Hours Months Min. 1 □ M 2 🕱 F Days 95 217-07-1599 Oct. 21. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 🎾 No Baltimore Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4300 Cardwell Avenue, Apt. 309 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Visiting Nurses Assoc. Secretary 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Graber Minnick Anna Owen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Beetree Court, Bel Air, MD 21014 Reems (daughter) Donna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any Injury or of
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/2007 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service 1 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the burial-trans resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown signed by the aid 5 Other (specify) 1 ☐ Yes 2 📉 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【★ No 24a. Was an page 2 has autopsy perform 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury 28b Time of 28d. Describe how injury occurred Injury at (Month, Day Year 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0059853 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Flanklin Sq. de Baltimore, MD 21287 Betsy SchradER 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FAnton, Habel

			FOI	epartment of Health and N	Mental Hygie	ene	
			1. Decedent's Name (First, Middle, Last)	Certificate of Death		. No.	3. Time of Death
	Physicia		CHARLES RICHARD FRAVEL		Februar	y 3, 2007	1:05P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	1.001
			Gilchrist Center	Towson		Baltim	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $206-12-9892$ $XX^{\square M}$ $^{2}\square$ F $82$	Months Dave Hours Min	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	place (State or Foreign ntry)
	Director		206-12-9892 XXX 82 YI	<u>.                                      </u>	February	13,1924	Pennsylvani
	yland now at		10a. State 10b. County 10c. City, Town	or Location		1	0d. Inside City Limits
	e Mar la-f sh tiffed	ctor	Maryland Baltimore Towson				1 □ Yes 2 □ No
	or 28	Dire	10e. Street and Number	10f. Zip Code	109	. Citizen of What Cour	ntry?
	s 23a	Funeral Director	1201 Malvern Avenue  11 Marital Status 12. Was Decedent Ever in U.S.	21204	agify Van ar Na	USA 14. Race - Americ	an Indian
	ter de	Fune	11. Marital Status  1 □ Never Married 2 ★ Married  1 □ Never Married 2 ★ Married  1 □ Never Married 2 ★ Married	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton</li> </ol>	o Rican, etc.)	Black, White,	
	ursal al',or Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:	White
	72 ho natur ilical	Completed	15. Decedent's Education 16a. C (Specify only highest grade completed) (	ecedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	king 16	b. Kind of Business/In-	dustry
7	ithin ne.	фш	Elementary/Secondary (0-12)   College (1-4or 5+)				-1.1
7	filed v Hygie ther t	ပ္ပိ	17. Father's Name ( <i>First, Middle, Last</i> )	ledical Doctor 18. Mother's Nam	ne (First, Middle, Ma	rivate Pra	ctice
<u></u>	d be ental ked o c eve	To Be	Noah Hockman Fravel		rubaker L	•	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	۲		Mailing Address (Street and Number or Ru			
2	and 2 ealth n 27 i			1 Malvern Avenue To			
5	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1XXBurial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of crematory or other place)	Date 20	c. Location - City or To	own, State
	t. Pa			idge Cemetery 2/8/		kesville,	
מ	Depar Impo any ir		21/Bignature of Funeral Service Licensee	22. Name and Address of Facility Mi			
	4100		23a. Part1. Enter the disease, complication, that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate
0.01	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of				ICAPI
	Examiner		Sequentially list conditions b.				
	pe ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	):			
	xecuti and Il-tran	xar	that initiated events resulting in death) Last  C  Due to (or as a consequence of	);			
2	icate be executed physician and s the burial-transit	edical E					
0	tificat ng phy as the						
20	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death	3 ☐Ectopic pregnancy		23d. Date of delive	•
5	ne des the at hed fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 ☐ Other (specify)		Month	Day Year
	that the		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
, olds,	uires sign	d by	Commany Artery Disease		1 ☐ Yes	2 No 3 Prob	pably 4 Tiknown
5	s beel	lete			24a. Was an	24b. Were auto	psy findings available mpletion of cause of
ב	The fa	Completed			autopsy performe 1 Yes 2 €	prior to co death? ₹No 1 ☐ Yes	mpletion of cause of
2	slan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?		th (Check only one)	,,,,	
5	physic this co	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			ce 6 DOther (Specif	y) Hospice
5	ding F	ion	investigation	me of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
2	Atten death ector:	fical	3 Suicide 6 Could not be 28e. Place of injury - At home, farm			et and Number or Rura	I Route Number,
Š	al or safter	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical (	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cau irred at the time, dat	se(s) and manner as s e and place, and due to	tated. o the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month,	Day, Year)
ł			I for Which MD	D0061199		-cb, 3, 100	7
	15		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	19 -	10.1	7,104
	Sta	te.	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (T  Tasen Black, CSG-Nav7h Chav7  31. Date filed (Mapth Day, Year) 32. Registrar's Signature	draules	01, (06	50 m 14/2	21207
	Registr		31. Date filed (Month, Pay, Year) 32. Registrar's Signature				

Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day THERESA FOLCARELLI 4,2007 7:30P M DOLORES FEBRUARY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, WHITE MARSH BALTIMORE 6039 LORELEY BEACH ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | 0 4 / 1 4 / 1 9 3 0 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Social Security Number Months 1 □ M 2 K F 76 MARYLAND 220 24 9884 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🛣 No MDBALTIMORE WHITE MARSH 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6039 LORELEY BEACH ROAD 21162 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STOCKROOM SUPERVISOR CLOTHING 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FRANK J. **JABLONSKI** HELEN KOSINSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AMERICO A. FOLCARELLI/SPOUSE 6039 LORELEY BEACH RD. WHITE MARSH, MD 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State METRO CREMATORY 2/08/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Sorvio Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTH disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it is leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar the signed by t has this certificate

The law requires that the death certificate be executed

Box 68760

O

Division or Vital Records,

To the Hospital or Attending

Completed within 24 hours after death.

To the Funeral Director: After completely filled in by the funera

Examiner

Physician/Medical

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Certification:

Medical

2/ No 1 🗌 Yes 27. Manner of Death

12 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

31. Date filed (Month, Day, Year)

FEB 0 6 2007 32 Registrar's Signature

State Registrar

		•	For State Registrar	State of Mary		rtment of H			ene g. No. 200	17	03258
			Decedent's Name (First, Middle, Last)					2. Date of Death		- 1	3. Time of Death
	Physicia		Dorothy Barbara	Fox				Month Feb.		oar 07	9:00 A
	/Medic Examin		4a. Facility Name (If not institution, give str	-		4b. City, Town, or	Location of Death		4c. County of E		7,00 11
			Catered Living of C	ockevsvil]	Le	Cockeys	sville		Baltim	ore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,	9.		ce (State or Foreign
	Director		220-14-1529	<sup>M 2</sup> ▼ 82	Yrs.	Monaro Buys	TIOGIO IVIIII.	June 16		MD	<u></u>
	p ,		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ration				100	d. Inside City Limits
	aryla shov	_								100	1 ☐ Yes X☐ No
	he M 8a-f otifie	Director	MD Baltimor	·e	Cocke	ysville 10f. Zip Code		1 10	g. Citizen of Wha	1 Countr	
	with t		10e. Street and Number				1030	100		SA	, :
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notified at	Funeral	4A Beehive Place  11. Marital Status	. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hi		necify Yes or No-	14. Race - /		ı Indian,
	iter d	ᇤ	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🔀 No		Yes, specify Cuba	in, Mexican, Puert	o Rican, etc.)		White, etc	
36	urs al	by	X☐Widowed 4☐Divorced	If Yes, Give Year or Dates:	1	☐ Yes 21 No	Specify:		Specify:	wh	ite
21215-0036	2 hou	ted	15. Decedent's Educa	tion	16a. Deced	ent's Usual Occup	ation	tina 1	6b. Kind of Busin	ess/Indu	stry
212	hin 7 e. an "n Med	ed l	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of NOT use retired	l)	King			
2	d wit	Completed	12	n/a	Но	memaker			Own Ho	me	
2	2 2 2 Q	Be (	17. Father's Name (First, Middle, Last)	_				ne (First, Middle, M			
<u> </u>	should be filed within 72 hours after death with the Marylan Ind Mental Hygiene. Ind Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show immatte event, the Medical Examiner must be notified at	2	John Bond Harris,	Jr.			Elizab	eth J. E.	lmos		
Maryland	2 sho and Is m		19a. Informant's Name/Relationship (Type Donald B. Fox/son	e. Print)				on, MD 2		ite, Zip C	(ode)
	es 1 and 2 should b of Health and Ment Item 27 Is marked r other traumatic e		•	T <sub>e</sub>			· ·			T	. 01-1-
altimore,	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ Rei		20b. Place of Dispo cemetery, crer	natory or other plac	e) 2/6/		0c. Location - Cit	y or row	n, State
≣	. Pa tmen tant: jury		4 Donation 5 Other (Specify)					Gardens T	imonium,	MD	
Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licenses	1000		. Name and Addres		ne of Dul	anev Val	lev.	Inc.
	□ □ = # O	H	Wanda Lemmer	we gen		O W. Pado	onia_Rd	_Timoniu	m. MD 21	093	
н		e 10	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	cause on each line.	death. Do not ent	er the mode of dyln	ig, such as cardiad	or respiratory arre	st,	1	Approximate nterval Between Onset and Death
	Physician	ñ	Immediate Cause (Final disease or condition resulting in death)	cu	au c	95811	Welly	lung	diffa	$\varphi$	
	/Medical Examiner		resulting in death)	Due to (or as a co	ensequence of):			1			
b		ē	Sequentially list conditions,	Due to (or as a co	insequence of):						
	ted nsit	nin	Saquartitative field to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	200 10 (0. 00 0 0							
-	xecu and	Examin	that initiated events c. resulting in death) Last	Due to (or as a co	ensequence of):	T = 1					
8760,	icate be executed physician and s the burial-transit	ia E									
687		edical	0.								
Box	The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome pf p					23d. Date of	of delivery	,
ă	death atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□ 4□Pregnant at tim		]Ectopic pregnancy ] Other <i>(specify)</i>			Month		Day Year
O.	the o	hysi	9 Unknown	9□Unknown							
ر. ص	s that ned t	Ϋ́	Part II. Other significant conditions cont	ributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the	cause of death?
Records,	w require been sig should b							1XYe	s 2 No 3	Proba	bly 4 □Unknown
ပ္ပ	sw respectively	ete						24a. Was an	24b. We	re autops	sy findings available
8	The lav	Completed						autopsy perform	ted? dea	ith?	pletion of cause of ? ☐ No
Vital			25. Was case referred to medical				26. Place of Dea	1 Yes 2 ath (Check only one		1168 2	
>	ysician: is certific director,	o Be	examiner?	ospital:	2 ER/Outpatier	t 3 DOA Oth	er: S/	lome 5 ☐ Reside		(Specify)	
ō	g Phys er this eral di	ü	27. Manner of D ath	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor		28d. Describe ho		, , , , , , ,	
<u>ö</u>	Attending Ph or death. ector: After th by the funeral	atio	1 Natural 5 Pending 2 Accident investigation	(Wester, Day 11	11,017		Yes 2 □ No				
Division or	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc. (5	- At home, farm, str Specify)	eet, factory, office		28f. Location (Str. City or Town,		or Rural	Route Number,
$\bar{\Box}$	tal or Ars after al Direction by	Çe									
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	cal	(Check only 2 Medical Examin		amination and/or in						
	the hin 24	Medical	one)	and manner stated	l.	200 Ligano	o numbor	00	od Data signad (	Month D	harr Vanal
	wit To	-	29b. Signature and title of certifier	7 . 1	11	29c. Licens	277.	7	od. Date signed (	VIOILII, D	ay, rear)
)	1		62041	cellou	111		610		4/1/		
	10		30. Name and address of person who cor	npleted cause of death	h (Item 23a) (Type,	Print) N. C.L	arless	A. Ba	Ho D	1	2120X
	Sta	ato	31. Date filed (Month. Day, Year)	32. egistrar's	Signature	1-0-	, ,	. 1041	,0000		
	Regist		FEB 0 6 20	07 Boliva	, S. A.	DE CONTRACTOR DE					

DHMH 17 Rev 1/2001

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Medical Examinat Inter tribit be multiped at 2008.

For State Registrar			,			cate of			ental Hyو ا	Reg. No.	U	1 1	0325
. Decedent's Name	First, Middle, L	ast)							2. Date of Dea	ath Day	,	Year	3. Time of Dear
MARIANO	J. FON	TANAZZA							FEBRUAL			2007	5:45 A.
a. Facility Name (If	f not institution, gi	ve street and nu	m <i>ber)</i>		4b.	City, Town, or	Location of	of Death		4c.	County	of Death	
VA MARYLA	AND HEAL	TH CARE					ERRY I				<u>C</u>	ECIL	
5. Social Security N		Sex 1⊠M 2□F	7. Age (In )			Inder 1 Year oths Days	If Under Hours	Min.	8. Date of Birt (Month, Da	v, Year)		Coul	place (State or For intry)
17-09-132 Usual Residence of		н –	92		113.				8/24/1	914_		MAR	YLAND
10a. State	10b. County		10c	City, Tow	n or Location	1							10d. Inside City Lir
MD	N/A			BAI.7	IMORE	CTTY							14 Yes 2
10e. Street and Nur						f. Zip Code				10g. Citi	izen of V	Vhat Cou	intry?
2226 WES	TVIEW RO	AD				2	1218			US	SA.		
11. Marital Status		12. Was Dec	orces?	n U.S.	13. Was E	Decedent of H	lispanic Ori an, Mexicar	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-		e - Ameri k, White,	can Indian, , etc.
	ied 2 Married	If Yes, G	2 □ No ive			es 2X No	Specify:				Specify	· WHJ	TTE
3 🛚 Widowed	15. Decedent's	Year or E	Dates: WW		Decedent's	Usual Occup	ation			16h Ki	ind of Bu	W.П.J isiness/ir	
	cify only highest g	rade completed)			(Give kind o	of work done OT use retired	during mos	t of workii	ng	. 55. 10	5, 50	. J	,
9TH GRAI		College (	1-4or 5+)		MANAGI	ER				F	COOD	STOF	RE
17. Father's Name		st)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumam	10)	
FRANK FO	ONTANAZZ	A					JOSE:	PHINE	E TAGLA	VIA			
19a. Informant's Na	ame/Relationship	(Type, Print)	TSTER-	TN- 196	. Mailing Ad	dress (Street	and Numbe	er or Rura	l Route Numbe	er, City o	or Town,	State, Zij	p Code)
MADV TANI			A T. T	T-14	0	DADITO	OD DO	۸D [	OMETA INC	DE M	ero os	123/	2
LIMIT ONIVI	<u>E FONTAN</u>	AZZA/ LA	A W		835 CI	LEARWO	JD RO		BALTIMO			1.65	
20a. Method of Disp	position		20	b. Place o	f Disposition				ate			City or T	own, State
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State

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D. VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32. Registrar's Signature

Registrar

D52739

FEBRUARY 3,

			1 - For Stata Registrar	State of Ma	ryland /		artment of H		Mental Hy	giene Reg. No:	) 7	032	260
	Physic	an	Decedent's Name (First, Middle,			1.			2. Date of De	eath Day	Yeer	3. Time o	
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ò	72 hours natural', ilcal Ex		15. Decedent's	Education	16	Sa. Deced	ent's Usual Occupa	ition		16b. Kind of Bu		ite	
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Maryland	Ment Ment arke	ဥ	Jonathan Chen	Kiat Franca-	-Koh			Ana Clau	idia Da'	Silva Fr	ranca		
Nar	2 sh and ism reum	0 8	19a. Informant's Name/Relationshi				g Address (Street a		ral Route Numb	er, City or Town,	State, Zip	Code)	
	t and tealth sm 27		Jonathan France 20a. Method of Disposition	a-Kon (Father			Spadderdo	ck Way	Laurel,	MD 2072			
Baltimore,	@ ° = 5		1 Surial 2 ☐ Cremation 3		cemer	tery, crem	atory or other place		Date	20c. Location -			1
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	Fnysician /Medical Examiner	9	23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury	a. TRISON Due to (or as a c	ly 13	e of):		, such as cardiac	or respiratory a	rest,		Approximatinterval Bet Onset and	tween
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.O. Box	at the death certifice by the ettending pt nached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 ( 4 □ Pregnant at tin 9 □ Unknown	☐ Fetal deat		Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	<u>.</u> *	Year
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	a care	edic	29a. Certifier (Check only one) 2 ☐ Medical Ex	Physician: To the best of naminer: On the basis of ex and manner stated	amination ai	e, death ond/or inve	occurred at the time estigation, in my opin	, date and place, nion, death occurr	and due to the cred at the time, d	ause(s) and man ate and place, ar	ner as sta nd due to t	ted. the cause(s)	
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	10	;	30. Name and address of person wh				rint)						
	-01		K. Perkins M.D. 31. Date filed (Month, Day, Year)	301 St. Pau		ce	Baltimore	e, Maryl	and 2120	)1			
	Stat Registra	~		2007 Segistrar's	100	A. Care	siles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** NORWOOD EUGENE GROSS, SR. Day /Medical 2007 FEB. 01 7:08P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4636 HAWKSBURY ROAD PIKESVILLE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours 78 217-22-7744 Director 03/01/1928 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~ " en Injury or other traumatic even." 10c. City. Town or Location 10a, State 10b County 10d. Inside City Limits **Funeral Director** MD BALTIMORE PIKESVILLE 1 ☐Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 4636 HAWKSBURY ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) KENNE COTT Elementary/Secondary (0-12) College (1-4or 5+) CRANE OPERATOR REFINEY CORP. 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK GROSS, SR. EDNA JOHNSON မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCY GROSS / WIFE 4636 HAWKSBURY ROAD, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place, HOLLY HILL MEM., GARDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/09/07 BALTIMORE CO., MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licenses 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD the inter the isease, or complications that caused the de ock or hear failure. List only one cause in each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Imme to e Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infinitely accesse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 25 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Director: / 2 Accident 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D003536

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

State Registrar

31. Date filed (Month, Day, Year) 0 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manshallup

BVANC

10 N

Greene St. Baltimore, MD 2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 9864 2-6-07 vt. State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month O2 01 2007 1210 Goins Ray C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Good Samaritan Hospital Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 13 9. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours 1 □ M **¾**□ F Yrs. SC 213-54-1955 64 Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 U.S.A. 3811 Grenton Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: <u>}</u> Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker House 7th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabelle Convers မ Samuel Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Monticello 19a. Informant's Name/Relationship (Type. Print) Gayle Convers-Daughter
20a. Method of Disposition 348 Montecello Ct. Glen Burnie, Md 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 2/9/07 Owings Mills, Md 21. Signatura Funeral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 3a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final iseas) or condition resulting in death) Athensclente Carelo vascelar Physician Years /Medical Due to (or as a consequence of): Examiner typer tensur Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 🗹 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1. p. demia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ို 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D Name and address of person who completed cause of death (Item 23a) (Type, Print) Rave Boulevard Baltimore, Way land Loch 5601 Scauggi

State

Registrar

31. Date filed (Month, Day, FEB 0

Year)

0 6 2007

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 4:17 PM JEMAL DANTE GROSS Jan 31 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore City N/A Hospital of Bultimore Sinai If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min ₩ 2□F 214-08-7608 37 Yrs. Director 07/05/1969 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD N/ABALTIMORE CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 5803 ROYAL OAK AVENUE usa 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: XXNever Married 2 Married 10 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) DELIVERY DRIVER FED-EX CORP. 12TH YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Mental h ROBERT GROSS GERALDINE WILLIAMS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:1
Department of Health ar Important: If Item 27 is eny injury or other trau GERALDINE GARRETT/MOTHER 5803 ROYAL OAK AVE., BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 02/09/07 BALTIMORE CO., MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD The Enter the Assession of complications that caused the rick or hear ailure. List only one cause on each line Approximate Interval Between Onset and Death leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm Cause (Final disease or condition resulting in death) 1 day Physician SROSIS /Medical Due to (or as a consequence of): Examiner month enducardity Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physician and hed for use as the buriel-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? detached for Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 1 Yes 2 No 3 Probably 4 Monknown HIV Deen 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P s after death. 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 000 Aordan M. Cummuns, MD January 31, 2007 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) MD Sina 32. Registrar's Signature Jordan M. Cummins, Sinai Hospital of Baltimore 31. Date filed (Month, Day, Year) marie State FEB 0 6 2007 1000 Registrar

07-00875 James Gardner

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

dames Gardner	1- For State Registrar		Pertificate of		a Mental Hyg	JIENE Reg.	No. 200	7 0026
Physician Medical Examine		•				Date of Death Month D	ay Year	3. Time of Death 0258 hrs
	4a. Facility Name (if not institution,	give street and number)	4		Location of Death	February 1, 2	4c. County of Death	
Funeral	Good Samaritan Hospit.  5. Social Security Number 6.		rs. last birthday)	Baltimore  If Under 1 Year	r If Under 24Hrs.	8. Date of Birth (	MM/DD/YYYY) 9. Bir	tholace (State or
Director	212-26-2196  Usual Residence of Decedent	M 2 F	76 Yrs.	Months Days	House Min	April1	3 , 1930 Foreig	
Naryland 28a-f show any lat once.	10a. State 10b. County MD Baltin		City, Town or Locati Carkville	on				10d. Inside City Limits  1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once		е	-	10f. Zip Code 21234		10g.	Citizen of What Coul USA	ntry?
er death w , or items r must be		ed 12. Was Decedent Ever in Armed Forces?  1 Yes 2 No	0	es, specify Cuban	panic Origin? ( Spec , Mexican, Puerto Ric		White, etc.	can Indian, Black,
ours aft attural" camine	15 December Education (Caracit	or Dates:	i) 16a. Deceden		ion (Give kind of worl		Specify.Whit	1
215-0036 be filed within 72 hours a neal Hygiene. rked other than "natura ent, the Medical Examin	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	Manage		DO NOT use retired	)	Maryland S	tandard
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e, MD 21 and 2 should Health and Me item 27 is ma traumatic en	Shiriley II. Gar	dner- Spouse					yland <sup>w</sup> 292	
	20a Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec  21. Signature of Funeral Service Lice	Removal from State Z	Cemetery	eran)	2/7/2	2007	oc. Location - City or Iiddle Riv	er, MD
Balti permit. Departi Import injury	Robert Biedelm	an per dvr	20,000				SVD-Ox.	ion Services 1
Physician /Medical	23a. Part I. Enter the disease, or co failure. List only one cause on	each line.						Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Hypertensiv Due to (or as a consequence	ve Athero	scleroti	c Cardiov	<u>ascular</u>	Disease	Death
Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequenc	e of):					
red nisit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					7
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3760, ificate be g physici s the buri		23c. If yes, outcome of pr	regnancy		Ectopic pregnancy	Т	23d. Date of delivery	
h. Box 687 the death certific ty the attending p ched for use as the	past 12 months?  1 Yes 2 No 9 Unkno	4 Pregnant at time of	f do oth	aldeath 3 Ler (Specify)			Month D	ay Year
i, P.O. B ires that the d signed by the be detached:		s contributing to death but no	ot resulting in the u	nderlying cause gi	iven in Part I.	23e. Did tobac	No 3 Prob	he cause of death? ably 4  Unknown
Division of Vital Records, tal or Attending Physician: The law require rs after death al Director: After this certificate has been sighed in by the funeral director, page 2 should be artification: To Be Completed			<del>-</del>	<u> </u>		24a. Was an autopsy performed	prior to c d? death?	opsy findings available ompletion of cause of
ital Reco				26.Place	of Death (Check only	1 Yes 2	No 1 ✓ Ye	s 2 No
of Vital Bing Physician: After this certification director, To Be Con.	1 Yes 2 No		✓ ER/Outpatient		Other Nursing H	ome 5 Res	sidence 6 Other	
on of \ nding Phy th r: After th e funeral		28a. Date of Injury (Month, Day,Year)	28b. Time of In		y at Work? 286 es 2 No	d. Describe how	injury occurred	
Division o spital or Attending hours after death meral Director: Aft y filled in by the fune Certification:	2 Accident Investig 3 Suicide 6 Could n 4 Homicide	ot be 28e. Place of Injury - A	at home, farm, stree	t, factory, office bu	uilding, etc. 28	f. Location (Stree or Town, State		al Route Number, City
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.		ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death occurr n and/or investigati	ed at the time, dat on, in my opinion,	te and place, and due death occurred at the	e to the cause(s) e time, date and	and manner as state	d. cause(s)
20	29b Signature and title of certifier  Coult	enA.	-	29c License O.C.M			ebruary 1, 2007	th, Day, Year)
	30. Name and address of person who Zabiullah Ali, M.D. As	o completed cause of death (It sistant Medical Examin		Street, Baltin	more, MD 2120	<u></u>		
State	31. Date filed (Month, Day, Year)	2. Registrar's Sign		2				
Registra	FEB 0 8 2007	pour 1	- Agrical					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician 10:45 A. STEPHANIE GALCZYNSKI January 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) Maria Health Care Center Baltimore 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Maryland Director 220-07-2044 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits "natural", or itams 23a or 28a-f ahow idical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "--- any highry or other traumation". U.S.A. 6401 N. Charle Street 21212 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ years Teacher Parochial Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph 2 Galczynski Ladislava Gutowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sr. Bernice Feilinger, S.S.N.D. 6401 N. Charles Street Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Villa Maria Cemetery 2-5-07 Glen Arm, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death THRUBOSIS Immediate Cause (Final CEREBRAL Physician disease or condition resulting in death) WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificete be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical anding pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ Yo 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by DOMENTI 2 ♣No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete has tirector, page 2 s autopsy performed? 2 240 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Medicai Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Coursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 2 14No 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 5 Pending death. ours aftar death.
nerei Diractor; A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerei C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To tha ! 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 700137 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis X. Carmody, 7505 Osler Drive Towson, Maryland M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

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			For State	State of Mar		d / Depa		t of H	ealth a		lental Hyg	giene		03266
			Registrar			001	uncai	COIL	Jean		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last	11)		_					Month	Day	Year	
	/Medic		Elizabeth	Agnes		George					January			12:50 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death		4c. C	ounty of Deat	
			Maryland Masoni						ysvil				Baltin	
	Funeral		5. Social Security Number 6. S	TH 253E		ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birt	hplace (State or Foreign untry)
	Director		220-18-7862	□M 2 🖁 F	92	Yrs.		.,			May 11	<b>,</b> 19	14 Ma	aryland
	2		Usual Residence of Decedent	1.	On Cib	, Town or Lo	antina							10d. Inside City Limits
	thow thow	_	10a. State 10b. County	1.	oc. On	, rown or Lo	Cation							1 ☐ Yes 2 🖾 No
:	e Ma	cto	Maryland Baltimo	re		Cocke	_							
	death with the Maryland rms 23a or 28e-f show rmust be notified at	Director	10e. Street and Number				10f. Zip	Code			•	10g. Citize	on of What Co	untry?
	23a	a	300 International	Circle				210					USA	
	dea dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.	S. 13. \	Was Dece	dent of Hi	spanic Orig	gin? (Sp.	ecify Yes or No- Rican, etc.)	14	<ol> <li>Race - Ame Black, Whit</li> </ol>	
•	or it		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give					Specify:				Specify:	
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ה ה	s filed within 72 hours after I Hygiene. other then "natural" or ite rent, the Medical Exantina	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Deced (Give	kind of wo	rk done d	turina most	of work	ing	16b. Kind	d of Business/	Industry
7	10 a	d	Elementary/Secondary (0-12)	College (1-4or 5+)		life. I	DO NOT u						_	
7	gien gien	Son	12	n/a			Fi	1e C					-	rance
and		Be (	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle,	Maiden S	iumame)	
<u> </u>		5	Pius Alphons	o Fishe	er	,			Et	he1		Ebl	berts	
ā	2 should be and Mental Is marked sumatic ev		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	s (Street a	and Numbe	r or Rur	al Route Numbe	r, City or	Town, State, 2	Zip Code)
Ξ	2 <b>5 5 5</b>		Francine E.G. Wal	.z/Daughter		224	Turn	wood	Driv		len Bur	nie,	MD 2	1061
<u>ē</u>	of Heatitam		20a. Method of Disposition	10 Chan	20b. P	lace of Dispo emetery, crer	sition (Na	me of other place	e)	1	Date	20c. Loc	ation - City or	Town, State
Баппто	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐  • A ☐ Qonation 5 ☐ Other (Specification)		Lo	udon P	ark (	emet	ery	2/5	/07	Balt	imore,	Maryland
	artm oorta inju		21. Signatura of Feneral Service Light	10m	201	00	Name of	ad Address	e of Escilib	.,		1	. 77-11.	Tm 0
ă	permit. Pages 1 Department of H Important: If its any injury or ot ance.	/	Lowell M. Lemm	lob XV//	1110	1	lemmo IU W.	n Fui Pade	neraı onia	ноп Road	e of Du , Timon	ium.	MD = 2	1093
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		ne deati	h. Do not ent	er the mod	de of dyin	g, such as	cardiac	or respiratory an	rest,		Approximate Interval Between
			Immediate Cause (Final	a. Acute	Ca.	1.110	1.10	, ,	2.00 1	X.				Onset and Death
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ğ	leath certificate attending phy: I for use as the	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti			⊒Ectopic p ⊒ Other (s						Month	Day Year
j.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	1 ☐ Yes 2 🂢 No 9 ☐ Unknown	9□Unknown										
J.	that ed by deta	ā	Part II. Other significant conditions of	contributing to death but	not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
Vital Records,	uires sign Id be	d b	Sympant Dener	tin. Hyr	eter	ser.	hic	At	nal		1 🗆 Y	′es 2□	No 3□Pi	obabiy 4 Unknown
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$\frac{3}{8}$	tend Jeath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	e 290 Place of Injur	u - At h	ome farm str					28f. Location /S	Street and	Number or Ri	ural Route Number,
Division of	or A offer Direction by	Certification;	4 ☐ Homicide determined	building, etc.			001, 140101	y, oo			City or Tou			
	pital ours a eral filled		29a, Certifier 1 Certifying Pt	nysician: To the best of	my kno	tseh enbelwe	h occurred	at the tin	ne. date an	id place.	and due to the	cause(s) a	and manner as	s stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Example)	niner: On the basis of e	xamina	tion and/or in	vestigation	n, in my o	pinion, dea	th occur	red at the time,	date and	place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)
)	- 3 - 3		D+ 41	1111			1	D 2.	V150			2/11	07	
	6		30. Name and address of person who	completed cause of dea	ath (Iten	n 23a) (Tvne	Print)	yal	704			1''	- 1	
	)		000.4	completed cause of dea MD. 350 8 32 Registrar	Ba	mh St	- Ba	lto	, nu	12	122Y			
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar	's Signa	ature /	20 %		/					
	Regist		FEB 0 6 2	007 Beren	, K	The Solar								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 542 PM **Physician** GUTHRIE 31 2007 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE

IF Under 1 Year | If Under 24 Hrs. | Min DOHNS HOPKINS BANGELI MEDICAL ENTER. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 218 18 9330 1 🗌 M 24, 1921 Director SHIP NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or Items 23a or 28a-f show Examiner must be notified at YYYes 2 No Funeral Director TURNER STATION MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1612 MELBOURNE ROAD 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: RT.ACK ð 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Mone. 10 HOME MAKER HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISAAC EASTER ပ AMANDA UNDERDUE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WANDA MILLER/DAUGHTER 202 FLEMING DRIVE, TURNER STATION, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
MEADOW RIDGE MEM. PK 02/07/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ELKRIDGE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS STREET, BALTO.. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 Hours Immediate Cause (Final disease or condition resulting in death) Physician MRACEREBRAL MEMORRHAGE /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Ce Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Tes Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 0 O

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State Registrar

30. Name and address PUTIGEN

31. Date filed (Month, Day, Year)

**ORIGINAL** 

of person who completed cause of death (Item 23a) (Type, Print)

2007

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTFM# 20a, per FH, C864, 2/12/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, **Physician** 2007 Keene Lambert Gooding, Jr. 7:40pm M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1294 E. Sandcroft Court Sykesville Carroll 8. Date of Birth (Month, Day, Year) Dec 25, 1946 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MD MD 1 M 2 ☐ F Months 60 218-46-9563 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1294 E. Sandcroft Court 21784 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chief of Parks & recereation Baltimore County Gov. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keene L. Gooding, Sr. Dorothy Mae Horn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1294 E. Sandcroft Ct. Sykesville, MD 21784 Mrs. Debbie Gooding (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dulaney Valley Mem.Gardens<sup>2/8/07</sup> 1 ■Burial 2 ■ Gremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Timonium, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Bo Sykesville, MD 21784 (410)-795-1400 PA (Box 195) Duan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastano **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the led by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed the should be detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a Was an funeral director, page 2; 1 Yes 2 No To the Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

Registrar DHMH 17 Rev 1/2001

completely

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State

(Check only

JANE

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Pegistrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

<i>,</i> .							
State of	Marylar	nd / De	partment	of Health	and	Mental	Hygiene

		-	_ FOF	epartment of Health and I Certificate of Death	vientai Hygie Reg.	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		JOAN RICKETTS GLASS		Month February	2, 2007 7:55 P.M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	n	4c. County of Death
	Examini		Friends Nursing Home	Sandy Spring		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9 Birthplace (State or Foreign
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	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th wi	<u>=</u>	851 Azalea Drive	20850		nited States
	ems	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
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2	filed Hygid ther int, th		17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Mai	iden Surname)
aŭ	d be	Be	Audley Ricketts	Marie	Nelson	
7	houling Me	၉		Mailing Address (Street and Number or Ri		ity or Town, State, Zip Code)
Maryland	id 2 s Ith ar 27 is trau			2 Dunton Terrace, I	Perry Hall	. Maryland 21128
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Baltimore,	artme artme ortan injur	1	21. Signature of Fune a Service Licensee			
Ва	permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once.		Chyslette Barret M01305	7557 Wisconsin Avenue,	Bethesda, Ma	
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	ne Ho ne Ful pletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and manner stated.	d/or investigation, in my opinion, death occ	urred at the time, date	e and place, and due to the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	29c. License number	29d.	. Date signed (Month, Day, Year)
			> Clurkon denus	D39793	Fe	bruary 5, 2007
	$\cap$		30. Name and address of person who completed cause of death (Item 23a) (			
			Christopher J. Mays, M.D., 18111 P	rince Philip Drive	#207, Olne	y, Maryland 20832
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Could &		
	Regist	ar	CER O 6 2007 Broke A.	\$200 See		

DHMH 17 Rev 1/2001

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Ö	afor after	Certification:	4  Homicide	,,,,,,,	building, etc. (Spec	city)					City or To	wn, State)			
	To the Hospital or Attending Physician: The twithin 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	sai C			To the best of my kr										
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	To t To T	Σ	29b. Signature and title of cert	tier			29	c. Licensi	50	S		29d. Date si	gned (Month,	Day, Year)	7
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1	4+1		30. Name and address of pers	on who complete	ed cause of death (Ite	m 23a) (Type.	Print)	2 17	1		MA	21	2/6	)	
	1	ate	31. Date filed (Month, Day, Ye	ar)	32. Sgistrar's Sign	nature		un	mor	<u> </u>	11/		-, 0		
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State of Maryland 7 Department of Health and Mental Hygiene 7 1 1 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 5:050 Jennery 200) /Medical tanlan Green Blatt 2 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Nu**8752** Haign- N Baltone 8. Date of Birth (Month, Day, Year) 08/02/1918 der 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 M 2 □ F Months Days Hours Min. 215-14-<del>1918</del> 88 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 8306 MARCIE DRIVE death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No WWII if Yes, Give 14. Race - American Indian, Black, White, etc within 72 hours after 1 Never Married 2 Married WHITE 'natural', or 1 ☐ Yes 2 X No Maryland 21215-0036 Specify: Specify: if Yes, Givo Year or Dates: þ NAVY 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. PROPRIETOR REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES GREENBLATT ROSE GREENFIELD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17011 TURKEY POINT - SAN ANTONIO, TX 78232 HAROLD GREENBLATT / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DRUID RIDGE CEMETERY 02/04/2007 PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. Ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): nouvener. /Medical Examiner MRSA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy The law requires that the death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 ☐ Unknown ate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate 1□ Yes 2□No 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury 28b. Time of nours after death.

Ineral Director: After the filled in by the funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ö within 24 hours a To the Funeral L the Hospital 🚁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200) 029085 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 310 COURT 010 21111 J-C Allan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Melus Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 04 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North west HOSPITA Saltimore 9. Birthplace (State or Foreign Unde 1 Year I 8. Date of Birth 5. Social Security Number **Funeral** 0771171918 Days Months Hours 1 ☐ M 2 🔽 F **BELARUS** 88 218-39-6499 Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a State 10b. County 28a-f show a or 28a-f show t be notified at 1 ☐ Yes 2 🕅 No REISTERSTOWN BALTIMORE Director MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21136 327 BRYANSTONE ROAD items 23a permit. Pages 1 and 2 should be filed within 72 hours after death ν Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: þ If Yes, Give Year or Dates: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) CHEMIST SCIENCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **KRECHMER** RUBINCHIK RACHEL AARON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 327 BRYANSTONE ROAD - REISTERSTOWN, MD 21136 RAISA MARDER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State HAR SINAI CEMETERY 02/04/2007 OWINGS MILLS, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Cem Mast 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading 15 min concause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the IF FFMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0 the detached 9 Unknown ģ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1∏ Yes Vital Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**=1**N 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or this funeral 27. Mann of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? After 1 (Month, Day Year) Hospital or Attending 5 Pending investigation Natural 1 Accident 1 ☐ Yes 2 ☐ No I hours after death.

Uneral Director: A

ely filled in by the fu death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the within 24 hours are.

To the Funeral Direct determined 4 ☐ Homicide 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North west Hospital Center Roda //storm mix 21/33 Mahesh

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

			State of Maryland / De	epartment of Health and M		•	03273
			1 - State Registrar	Certificate of Death	Reg.	No.	00170
3	Physicia	an	Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Medic		LORK WINE HARPCK  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	, , , ,	4c. County of Deatl	
	Examin	er	MIMING SIDE HOUSE OF SAFR HILL	PARRUILLE		BACTIN	26 60
de de	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth	9 Rid	nplace (State or Foreign untry) yland
	Director		216-18-4157 1 M 2 X F 84 Yn	S. William Days Hours Will.	(Month, Oay, Ye 3/21/1	922 Mar	yland
	land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	Many -f sh	to	MD Baltimore P	arkville			1 ☐ Yes 2 No
	r 288	lrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	th wit	a D	9804 Harford Rd.	21234		USA	
	r dea	ner		<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show amy injury or other traumatic event, the Murical Earth, art must be notified at ODE.	by Funeral Director	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 X No If Yes, Give 3 Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 🏋 No Specify:		Specify: W	hite
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yla	i Men narke	2	Frederick Buettner  19a. Informant's Name/Relationship (Type, Print)  19b. N	A L III  Mailing Address (Street and Number or Rur	a Simms	tras Tourn State 7	Tio Codo)
Maryland 21215-0036	d2sh thanc t7 len traun			802 Harford Rd.			
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Baltimore,	partm portal portal portal		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Я	800 Har	ford Rd.
Ö	Ded Line		What Shell	Evans Funeral Ch And Cremation Se	apeı Pa rvices	rkville	, MD 21234
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)  Due to (or as a consequence of)				1
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68 ×	death certificate t e attending physion of for use as the t	Physician/Medi	IF FEMALE:				
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 mgnths?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	Day Year
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Ö		Certification:	4 Homicide building, etc. (Specify)		City or Town, S	rare)	
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	To the li within 2. To the is complete	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
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	nD		30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)		2/0/07	
	70		WENDY KLOESZ MO 6701 H CHAN	ucs of Suite 420.	- Tows	w mo	21264
		ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature	1.11.			
	Regist	rar	FEB 0 6 2007 May A	ADDAMA.			

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	artment of F	lealth and f	Mental Hygie		03274
	Physici	an	1. Decedent's Name (First, Middle, Last,					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Richard Jacob	Higgins					2, 2007	10:35 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give			4b. Cily, Town, o	or Location of Death	1	4c. County of Death	
			Upper Chesapeake  5. Social Security Number 6. Secu				el Air	10.0-11.15	Harfor	
	Funeral Director			7. Age (mys.	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
			Usual Residence of Decedent	/4				Jan. 12,	1933 Pen	nsylvania
year	Mod M		10a. State 10b. County	10c. C	ity, Town or L	ocation				10d. Inside City Limits
W	ine d	cto	Maryland Harf	ord		Abing	don			1 ☐ Yes 2 🕅 No
1	or 21	Funeral Directo	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Cou	ntry?
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90	iten d	nu.	11. Marital Status  1 ☐ Never Married 2 🔀 Married	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of F If Yes, specify Cub	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
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aitimor	artme orteni injury		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License			Crematory			altimore, l	Maryland of Bel Air
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			23a. Part1. Enter the disease, or compl	ications that caused the dea						Approximate
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DIVISION OF VICE	within 24 hours after death.  To the Funerei Director: After completely filled in by the funer.	edical	29a. Certifier 1 Cartifying Physical (Check only one) 2 Madical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tire vestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
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-	- 5 - 0		1 Manaida	THE MALLON V	W	70	026.318			
	0		30. Name and address of person who co	impleted cause of death (Iter	m 23a) (Type,	Print)	- W			
	D		Roman E. T.	was up	344	S.E Boy	Hill Corp	Cuty Br,	Abindon	w 2(009
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	di .				,

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene

DIAIN OTAIN		1- For State Criticate of Department of He Registrar Certificate of De		,,	eg. No. 200	7 0397
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vicultai Examin			y, Town, or Location of Deal		4c. County of Death	0230 11/5
			timore		n,	
Funeral Director		$213-21-9038$ $\chi \chi M$ $_2 F$ $23$ $_{Yrs.}$	nder 1 Year If Under 24Hi nths Days Hours Mi	_	th (MM/DD/YYYY) 9. Birt Foreig Cou	
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	<del>-</del>	_		10d Inside City Limits
	5	Md Baltimore Windsor M:	111			1 Yes 2 XNo
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vith the	밀	3443 KIPPLE KOAD  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Dece	21244 edent of Hispanic Origin? ( §	Specify Yes or No-	USA 14. Race - Americ	can Indian Black
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212 ould be d Ment s mark	ည	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Addre	ess (Street and Number or	Rural Route Num	ber, City or Town, State,	
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		Roger Lee Holliman/Father   3443   20a Method of Disposition (120b. Place of Dispositi	Ripple Rd.,	Winmds	sor Mill,	
IOFE, ges l a t of He : If ite		1 X Burial 2 Cremation 3 Removal from State  4 Departion 5 Other Specify:  King Mem.	ce)	/6/07	Woodlawn	
Iltim nit. Pa artmen sortant	_	4 Donation 5 Other Specify: NIII PEIII • 2 Signature of Funeral Service Legisee / 22. Name a	nd Address of Facility Wy			
Ba perm Dep Injuri		SPANON V. Cegle 19200	Liberty Rd	., Rand	dallstown,	
Physician /Medical		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mox failure. List only one cause on each line.	le of dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wound to back  Due to (or as a consequence of):			<u> </u>	Death
	Ļ	Sequentially list conditions, b				
	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
secuted and -transit	EX	events resulting in death) Last Due to (or as a consequence of):  d.				
e exect cian an	Medical Examiner	UNPENDED AMENDED	-	<del>-</del> .		
760 ficate b g physi	-	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dec	45 2 Fotonio progra		23d. Date of delivery	
Sox 687 leath certific e attending p	sician	past 12 months?  4 Pregnant at time of death 5 Other (S		ancy	Month D	ay Year
Division of Vital Records, P.O. Box 68760, ra for attending Physician: The law requires that the death certificate be as after death.  al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	Phys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I	23e Didto	bacco use contribute to t	he cause of death?
P.C	[ゑ	Some parties of account parties	ing daddo givon in i art i.		2 No 3 Prob	
ords, w requir	Completed			24a. Was a		opsy findings available ompletion of cause of
Reco The law cate has	ĕ			perform	med? death?	
ital Recition: The section, page	8	25. Was case referred to medical examiner? Hospital: 4   Inspiral: 4   I	26.Place of Death (Check			
n of Vi	은	1 Ves 2 No Parametric 2 Exposurpatient 3 28b. Time of Injury 28b. Time of Injury	DOA Nursi  28c. Injury at Work?		Residence 6 Other:	
ion (tendin leath tor: At the fur	Certification	1 Natural 5 Pending FOUND: Pay, Year) FOUND: 2 Accident Investigation Feb 1, 2007 FOUND: O220 hrs	1 Yes 2 ✔ No	Subject was		
Divis pital or At ours after deral Direct filled in by	Ę	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.	or Town, St	treet and Number or Rur	
lospita t hours uneral		29a. Certifier 1 Certifies Physician To the heat of my knowledge, death conversed at	the time date and place an		2nd Street, Baltimore	
Division of Vital Records, P.O. Box 68760, within 24 hours after death  To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
F 3 F 3	S	29b. Signature and title of certifier	29c, License number		29d. Date signed (Mon	th, Day, Year)
		hy hi, ms	O.C.M.E.		February 1, 2007	
5		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Ling Li, MD Assistant Medical Examiner 111 Penn Street, Ba</li> </ol>	Itimore, MD 21201			
Sta	ate	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	9			
Registi	rar	FEB 0 6 2007 Steren & Spent	AT			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Catherine V. Hoch /Medical 4a. Facility Name (If not institution, give street and number) Fown, or Location of Death 4c. County of Death Examiner sedale 10 8. Date of Birth (Month, Day, Year) Oct. 26, 1927 If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday, Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Months Min. 1 ☐ M 2 🔀 F Maryland 79 214-22-5086 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√2 No Baltimore Director MD Essex 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21221 8620 Kelso Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Expensions. Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Baltimore County 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland Pugh Anna Ritter ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert J. Hoch Jr /son P.O.Box39 13370 Brighton Down Rd. 21029 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ☐Removal from State Holly Hill Cemetery 2/7/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD anu Connelly Funeral Home of Essex 21221 death. Do not enter the mode of dying, such Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final ocard **Physician** disease or condition resulting in death) /Medical Due (or consequence of): Examiner vonan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner 1 TO 1 and The law requires that the death certificate be exec resulting in death) Last Due to (or so on equence of): attending physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by er significant conditions ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Tes 2 No 3 Probably 4 Nonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has autonsy perfor 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes 2 K ER/Outpatient 3 □ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suici 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homic filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl one)

P.0. Division or Vital Records, within 24 hours after death To the Funeral Director: Hospital completely

2

State Registrar

31. Date filed (Month, Day, Year) 6 2007

Be.

30. Name and address of person who

29b. Signature and

title of certifier

use of death (Item 23a) (Type, Print) complete WA 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician February 2, 9:29P M THOMAS WALTER HEILAND 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St Joseph Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 5,1957 9. Birthplace (State or Foreign **Funeral** Months Days Hours 49 212-70-3635 Germany Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits <sup>1</sup> □ Yes χ2√ No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 21212 507 Windwood Road USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIvo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X2X☐ No Specify: White Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) marked other than Elementary/Secondary (0-12) Hygiene. Sales Manager Automation Technology permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Max Heiland Anna Marie Abrams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 507 Windwood Road Baltimore, Maryland 21212 Barbara Lee Heiland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GreenMount Crematory 2/5/07 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Seg 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Immediate Cause (Final SINGLE VENTRICLE Physician 49 TRS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. End of Janying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ned by the a edetached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CONDESTIVE HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 1 ☐ Yes 21 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) P No 1 Inpatient ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hospital or Attending Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21287 MD SOHNS HOSPITAL THOME 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician HANDLTR** 02 02 2007 1931 **EVA** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 88 Days 217-09-4976 Director 7-8-1918 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at GRANTSVILLE MD GARRETT 1 Tyes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 151 ROOT BEACHY ROAD 21536 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give' Year or Dates: 14. Race - American Indian, 'natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: WHITE þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) RETAIL SALES permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If Item 27 Is marked other tha any Injury or other traumatic event, the once. 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN KENNEY **EVA** (KOENIG) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21536 19a. Informant's Name/Relationship (Type. Print) LINDA SCHWEINSBERG/DAUGH. 151 ROOT BEACHY ROAD GRANTSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State GARDENS OF FAITH 2-7-2007 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME ature of Funeral Service Licensee 21237 1211 CHESACO AVENUE ROSEDALE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 2 No 24a. Was an autopsy performed?
Yes 22 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fr 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 31. Date filed (Month, Day, Year)

KALPANA

akala

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DOCTOR

D0059554

JAN 31, 2007

			For State Registrar	State of Ma	arylan		artmen rtificat				R	eg. No.		03280			
	Physici		Decedent's Name (First, Middle, Lass     IDA	НΔ	ANENBAUM 2. Date of Death Month						Year	3. Time of Death  3:45P M					
5	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		1171			Location of		FEB,	4c. County of Death					
			LEVINDALE							IMORE			N/A				
	Funeral Director		5. Social Security Number 6. Se 1[	7. Ag	94 (In yrs. 1	as <i>t birthday)</i> Yrs.	If Under Months	Days	If Under Hours	Min. 8.	Date of Birth Month Day 04/18/	Ĭ <b>9</b> 12	9. Birth Cou	place (State or Foreign ntry) POLAND			
1	D.		Usual Residence of Decedent			, Town or Lo					0.7.207		J				
	72 hours after deeth with the Maryland natural; or iteme 23a or 28a-f ehow dral Examinat must be mailfied at	j.	MD BALTIMO							10d. Inside City Limits 1 ☐ Yes 2 🏋 No							
	the M	Funeral Director	MD BALTIMO	JKE	DAL	TIMORE	10f. Zip	Code			1	0g. Citizen of	f What Cou				
	th with	al Di	35 BARBICAN WAY						2120	3			USA				
	r dee	Iner	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔥	Ever in U.	S. 13.	Was Dece	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Specif	y Yes or No- an, etc.)		ace - Ameri ack, White,				
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Never Married 2 Married 1 Yes 2 Married 1 Y			1 🗆 Yes	2 🕅 No	Specify:			Spec	eify:	WHITE			
21215-0036	2 hou	ted	15. Decedent's Ed	ucation		16a. Dece	edent's Usual Occupation					16b. Kind of Business/Industry					
21	within 7 lene. then "r	Completed	(Specify only highest grad	College (1-4or 5	5+)	(Give kind of work done during most of working life. DO NOT use retired)  BOOKKEEPER						BUTCHER					
	filed w Hygier ther ti	S	17. Father's Name (First, Middle, Last)			BUUK	KEEPE	IK	18. Mothe	er's Name (F	First, Middle, i						
an	iould be i Mental I harked o	To Be	ISAAC		S	CHONEB	AUM		ANN				,	GERSTEIN			
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f ehow other traumatic event, the Middical Examinar insaft be natified at		19a. Informant's Name/Relationship (7				-				loute Number			p Code)			
	1 and 1ealth 1m 27 ther tr		ZELDA ZABEN / NII  20a. Method of Disposition	ECE	20h P	35 B			VAY -	BALIJ	MORE,	MU Z1Z 20c. Location		own State			
nor	ages int of the t: if its		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		С	FE ZED	natory or c	ther plac	,	02/04/		BALTIN	-				
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 2002.		21. Signature of Juneral Service Licen		KOD		. Name ar				LEVINS						
ñ			Acett YII.	Cutter	h	8	900 F	REIST	TERST					MD 21208			
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CEREBRO VASCULAR A-CODENT  Due to (or as a consequence of):											Approximate Interval Between Onset and Death			
8760,	eath certificate be executed attending physicien and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):														
P.O. Box 68	O O	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	death 3	Ectopic p						Date of delive	rery Day Year			
	requires that the een signed by th rould be detache	Completed by P								obacco use contribute to the cause of death?  Yes 2  No 3  Probably 4  Unknown							
S	> 0 5	piete	ATRIAL FIB	RILLAID	) N						24a. Was a		. Were aut	opsy findings available ompletion of cause of			
- R	The ete ha	Com									perfor	med?	death?	2 □ No			
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			Check only or						
to o	this al di	. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatier 28b. Time o		28c. Injury Work			5 Reside			rfy)			
ion	Attending I r death. sctor: After by the funer	atior	1 Natural 5 ☐ Pending investigation	(Month, Da	y Year)	Injury	М		k? Yes 2 ☐	No							
Division of Vital Records,	el or Atte s after des si Directo	Sertific	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At ho	ome, farm, str	reet, factor	y, office		28	Location (S. City or Town		nber or Rur	al Route Number,			
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical Certification;	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	f examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	d place, and th occurred	d due to the c at the time, d	ause(s) and r ate and place	manner as s	stated. to the cause(s)			
	withi To ti	Σ	29b. Signature and title of certifier	100 00 000 11					e number	3		9d. Date sign					
,	1		Johnson H. h					1) 00	65	327		02/0	02/2	2007			
	(e		30. Name and address of person who co					VEN	FRE	AVE	13171-	TIMOR	EIM	1) 2/2/5			
- 15	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistr			A Tab	-				. , , , , , , ,	- //				
1	Regist	ar	CED O C	בחחב	2000	B. 1	7000	3									

DHMH 17 Rev 1/2001

Dhysisis		State Registrar  1. Decedent's Name (First, Middle, Las	t)	00	rtificate of l	Dealii	2. Date of De			3. Time of Death		
Physicia /Medic			Marianne Hy	Month Jar	Day Nuary 30, 2	Year 007	1:45 p. M					
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of D			y of Death			
			6449 Oaken Door				Columbia		Ho	ward		
-uneral Director		218-52-7813	2x 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year   Months   Days	Hours N	Hrs. 8. Date of Bir /Month, Da July 16	th ly. Year) , 1947	9. Birthp Cour	place (State or Foreig htry) Maryland		
3		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				1	Od. Inside City Limits		
d a ball	ō	M. Janet Ha					1 ☐ Yes 2 N					
7.28a	Director	Maryland H0  10e. Street and Number	ward		10f. Zip Code	Columbia		10g. Citizen of	What Cour	ntry?		
23a o	a D	6449 Oaken Door	21045	5		U.S	.A.					
L	ner	11. Marital Status	ispanic Origin	(Specify Yes or No uerto Rican, etc.)		ce - Amend						
or it	프	1 Never Married 2 Married	Armed Forces?  1 XYes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	72	1 ☐ Yes 2 XNo	Specity:		Speci		White		
li Ex	Completed by Funeral	3 Widowed 4 □ Divorced	Year or Dates:	183	/ \							
nation	lete	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of	working	16b. Kind of 8		•		
the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 5+			· tered Nurs	se		Healt	ncare		
other	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden Suma	me)			
rked lic ev	10 B	Curtis Ja	ames Baird				Eliz	abeth Rat	hbun			
e ma		Curtis James Baird  19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural Route Number, City or Town, State</i>										
n 27 i		Ms. Ella Merritt	Authorized Rep			Or. #301 /	Arlington, Virg	inia 22202				
o th		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cre.	osition (Name of matory or other place	:ө)	Date	20c. Location	- City or To	own, State		
ant:	Ш	4 □ Donation 5 □ Other (Specify		Bay	view Cremato	rv	02/06/2007	4	Baltimo	re, MD		
Important: If the 27 is marked other then "naturel", or iteme 28a or 28a-f ehow any injury or other traumatic event, the Modical Examiner must be notified at 2008.		21. Signature of Funeral Service Licen.	abhiol + Mr		2. Name and Addres	ss of Facility Funeral He	ome, P.A.					
sician edical		23a. Part1. Enter the discase, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that baused the decore cause on each line.  a	TKS	ter the mode of dyin	ng, such as car	bia Pike Ellico diac or respiratory a	rrest,	21045	Approximate Interval Between Onset and Death		
ysicie 10 bu	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.	equence of):	११२०५१०							
y the ettending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	23c. If yes, outcome of preging 1  Live birth 2  Fe 4  Pregnant at time of 9  Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year			
n signed buld be deta		Part II. Other significant conditions or	ontributing to death but not re		tobacco use contribute to the cause of death  Yes 2 No 3 Probably 4 Munkm							
S C1	Completed						24a. Was autop perfo 1 □ Yes			psy findings available impletion of cause of 2 No		
ertific ector,	Be	25. Was case referred to medical examiner?			1		Death (Check only o	one)				
this o	2	1 Yes 2 No		☐ ER/Outpatier		4 🗆 Nursir		dence 6 □Ot		y)		
<b>₽</b> ø	6	27. Manner of Death  1. SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2∐No	28d. Oescribe	how injury occu	rred			
After ti funera	= 1	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st		163 2 100	28f. Location ( City or To		umber or Rural Route Number,			
Director: After the in by the funeral	ertifica	4 Homicide determined	building, etc. (Spec									
24 nouts after death. Funerei Director: After the stely filled in by the funera	dical Certification:	4 Homicide determined  29a. Certifier TCCcrtifying Ph	ysician: To the best of my kr	nowledge, deat	h occurred at the tin	ne, date and p	ace, and due to the	cause(s) and m	nanner as si	tated. the cause(s)		
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			1 - State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of l			ene	7	03282
	4. y.	0)	Decedent's Name (First, Middle, Las	t)				2. Date of Death			3. Time of Death
ŀ	Physici	_	Michael Joseph	Juhasz				February	1, 2	Year 007	12:27 A M
and a	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County	of Death	
			2 Saddle Top Ct	Apt 2 D		Cock	eysville			alti	more
	Funeral		Social Security Number 6. S.		(In yrs. last birthday)	If Under 1 Year Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 23,	Year)	9. Birthp	lace (State or Foreign
	Director		368-98-4351	XDM 2□F 22	Yrs.	WOTHITS Days	Tiodis iviii.	Aug. 23,	1984	Penr	isylvania
	p v		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	eho •	5									1 ☐ Yes 2X No
	79 N	Director	Maryland Balt:  10e. Street and Number	imore		10f. Zip Code	sville	10	g. Citizen of V	Vhat Cour	10/2
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	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f ehow the Madical Ever'the front land for inclified at	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.			pecify Yes or No-			can Indian,
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36	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	Whi	te
Ą	2 ho	Completed	15. Decedent's Ed	ucation		dent's Usual Occu		rting 1	6b. Kind of Bu	siness/In	dustry
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2	gien gien er th	NO.		4 Years		ectrical	Engineer			AI	
2	al Hy	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M.	aiden Sumam	Θ)	
<u>ya</u>	Ment Ment mrke	2	Mark Juhasz				Mari	lyn Treba	ıc		
Maryland 21215-0036	and and as ma		19a. Informant's Name/Relationship (7	Type, Print)				aral Route Number,			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. important: if Itam 27 is marked other than "naturel", or Items 23a or 28a-f ehow emy Injury or other traumatic event, tra Madical Exercit artificial Exercities and once.		21. Signature of Funeral Service Licen	See	1			imunek Fu il Rd., B			of Bel Ai: 21014
38760,	Physician / Medical Examiner   Physician and // Websician and // Physician and // Its physician and // Physi	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.	consequence of):  consequence of):  consequence of):	<u> Lungh</u>	at Wound	to he	ad		Onset and Death
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	tw requires that s been signed b t should be deta	by Pt	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	underlying cause g	iven in Part I.	23e. Did toba	cco use conti	ribute to the	ne cause of death?
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ta		0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2	•	195	AL NO
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0	g Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	of 28c. Inju	ury at				finflicted
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	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (		ysician: To the best of niner: On the basis of and manner stat	examination and/or in						
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	20		30. Name and address of person who	completed cause of de	ath (III m 23a) (Tipe	Print)	اعا م	anilla .	11	210	00
	9		31. Date filed (Month, Day, Year)	2 No Pro D	's Signature	wie H.II	LI. LUTI	J C BHINE	40 6	10	70
	Sta Regist		825 25th 200	32. Hegistra	is signature	P TO TO		•			

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1/ per th 9864 2-6-07 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Lockett Sr. Douglas lebruary 30 2007 00: /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 10 12 16 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2 □ F 90 VA Director 234-14-2982 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anones. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No MD NA Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 4003 Spruce Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County 12th grade College (1-4or 5+) Vice Principal Public Schools 17. Father's Name (First, Middle, Last)
Willis
William Lockett 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Sallie Twitty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Garrison-Daughter 6320 Greenspring Ave Apt 403, Balto, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2/9/07 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Signatur of Funeral Service Licensee 21215 #11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final **Physician** Backial Pneumnia dixase or condition sulting in death) week /Medical Due to (or as a consequence of): Examiner Small browd obstruction week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included assets) Due to (or as a sone equence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? Yes 2 No certificate 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Thpatient 2 ER/Outpatient 3 DOA မှ After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) nexander us AT 2438946 Lebruary 2,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h 32. Registrar's Signature ) anelle Muxander Memorial Mospital 31. Date filed (Month, Day, Year) State FEB 0 6 2007

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 3, **Physician** 8:40 P Charles William Louis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Center Towson Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 78 212-28-1120 29. 1928 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4422 Parkside Drive 21206 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Administrator Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Doretta Wetzel Louis ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 Brant Drive. Dallastown. PA Robert Louis 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Entombment Parkwood Cem. Maus. 2/6/2007 Baltimore. Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Leion o Jaicom MICHT45 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an ate has page 2 s autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospic. 1 Yes 2 No 1 🔲 Inpatient P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6585 North Charles ST Scite 209. Touson. MD 21204

State Registrar 31. Date filed (Month, Day, Year) FEB 0 6 2007

13/ack



07-00927 Charles Lewis

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ilanes Lewis		- For State	Cei	rtificate of		a mornar ri		. No.	
Physician	/	I. Decedent's Name (First, Middle,La	st)				2. Date of Death	201	3 Time of Death Z
Medical Examine			F.		Lewis J		Month February 2,	2007	2135 hrs
$\bigcirc$	4	4a. Facility Name (if not institution, gi 221 East Street	ve street and number)		4b. City, Town, or Baltimore	Location of Death	4c. County of Deat	h 	
Funeral	1	5. Social Security Number 6. S	ex 7. Age (In yrs. i	last birthday)	If Under 1 Yea			Forei	rthplace (State or
Director		217-34-3993 X	M 2 F 69	Yrs		S FIGUIS IVIII.	08 0	8 37 0	ountry) MD
, any	-	10a. State 10b. County	1	, Town or Locat					10d. Inside City Limits
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th the Maryland 23a or 28a-f sho notified at once.	Sel .	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
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death		1 Never Married 2 Marrie	1 Yes 2 X No			n, Mexican, Puerto	Rican, etc.)	White, etc.	7 1-
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2 hours af		Elementary/Secondary (0-12)	College (1-4 or 5+)			e. DO NOT use reti			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene, Inatt: If tiem 27 is marked other than or other traumatic event, the Medical	⊆ !	9th grade	na	L	aborer				rt Cup Co.
filed vill Hygi	1	17. Father's Name (First, Middle, Las	_			18.Mother's Name	•		
212 Muld be Menta mark	9 P	Charles F. Lew 19a. Informant's Name/Relationship	Type, Print )	19b. Mailin	g Address (Stre	et and Number or F	Rural Route Numi	nkscales ber, City or Town, Stat	te, Zip Code)
MD d 2 sho lth and n 27 is	L	Mary Baylor-Si	ster	4003	Belvie	eu Ave,	Baltim	ore, Md_	21215
ore, es 1 an of Hea If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3		Place of Dispos crematory or of	sition (Name of ce ther place)	emetery,	Date	20c. Location - City of	or Town, State
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Bal permi Depar Impo injur		2 It signature of Furieral Service Lice	ALLOW!	Ma 43	Name and Addres rch F/F	i West sh Ave	Balti	more, Md	21215
Physician	1	23a/Part I. Enter the disease, or con failure. List only one cause on		h. Do not enter	the mode of dying	, such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
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	1	or condition resulting in death)	Due to (or as a consequence of	of):					
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ed isit	Examine		Due to (or as a consequence	of):					
760, cate be executed physician and the burial - transit	Medical	X UNPENDED	a	g864 2/2	21/07 TT				
760, icate be physic the bur	Me.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre-	gnancy				23d. Date of delive	,
Box 687 e death certific the attending p	Clan	past 12 months?	1 Live birth 4 Pregnant at time of d		etal death 3 other (Specify)	Ectopic pregna	ancy	Month	Day Year
Bo)	Physician/	1 Yes 2 No 9 Unknow	9 Unknown			6-11	One Did to		to the cause of death?
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific as fler death.  "al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be deached for use as the control of the control o	2	Part II. Other significant condition:	s contributing to death but not	resulting in the	underlying cause	given in Part i.			obably 4 🗸 Unknown
rds, require been si	Completed						24a. Was a		autopsy findings available ocompletion of cause of
ecol he law rte has	Ĕ			· · · · · · ·			perform	med? death?	
al R	Be C	25. Was case referred to medical			26.Plac	ce of Death (Check	only one)		
Vit.	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier				Residence 6 🗸 Oth ow injury occurred	er: Scene
anding 1		27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of		ury at Work? Yes 2 No	28d. Describe II	ow injury occurred	
livisior I or Attend after death Director:	licat	2 Accident Investiga	28e Place of Injury - At I	home, farm, stre	eet, factory, office	building, etc.			Rural Route Number, City
Div pital o ours aft eral D	Certification:	4 Homicide determin					or Town, St	ate)	
	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	cian: To the best of my knowle er:On the basis of examination and manner stated.	dge, death occu and/or investiga	urred at the time, o ation, in my opinio	date and place, and on, death occurred	d due to the cause at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
E 3 E 8	¥	29b. Signature and title of certifier	1//			nse number		29d. Date signed (N	
		N	VI.		0.0	.M.E.		February 3, 200	) <i>(</i>
		30. Name and address of berson wh Jack Titus MD. Deput	o completed cause of death (Ite y Chief Medical Examine		enn Street, Ba	altimore, MD 2	1201		
Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signa		41				
Registr	ar	FEB 0 6 200	A CONTRACT OF	STEE STEE					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			, , , , , , , , , , , , , , , , , , , ,	C	ertificat	e of E	Death		ay	Reg. No.			"col "orl long	
	Disconici		Decedent's Name (First, Middle, Last)     Date of Death  Mosth  Day  And Day  A										3. Time of D	Death			
	Physici /Medic		Stephani	Le			Lechowicz						February 4, 2007 10:00 AM				AM
	Examin		4a. Facility Name (			1 0		4b. City	Town, or I	Location	of Death		4c. (	County of D	eath	A.A.T.	
			Baltimore				nter	5	en	Gur	nie			ne A	run	del	
	Funeral Director		5. Social Security N 217-07-55	523	.Sex I□M 2∏F	7. Age (In yrs. 94	last birthda Yrs.	Months		If Under Hours	Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) MD				y)	Foreign
	pur *		Usuel Residence of Decedent  10a. State 10b. County t 0c. City, Town or Location												100	d. Inside City	i I Imita
	aho aho	5	MD	Anne Ar	ındel		en Bu:								100	1 ☐ Yes 2	
	the N	ect	10e. Street and Nu			- 01	en bu		0.4				10: 00:				
	23a or	Funeral Director	371 Duby					t Of. Zij	2106	61				en of What	Country	y?	
DIE 036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f show any Injury or other traumatic avant, the Medical Exacultar must be notified at once.	by Fune	t 1. Marital Status t ☐ Never Marr 3 🛣 Widowed	ied 2∏ Married 4	Armed F	2 XNo	J.S. 13	Was Dece If Yes, spe 1 \(\hat{\pm}\) Yes				fy Yes or No can, etc.)		4. Race - A Black, W Specify:	hite, et	C.	
2 <b>%</b>	72 hc natur	eted	(Spec	15. Decedent's		)	16a. Dec	edent's Usu re kind of wo	al Occupat	ition	t of working		t 6b. Kin	d of Busine	ss/Indu	stry	
Skephani 121215-003	iene.	Completed by	Elementary/Seco			(1-4or 5+)	life	nemake	se retired)	oring mos	i or working	Own Home			P		
ω <u>Β</u>	illec I Hyg othe	Bec	17. Father's Name	17. Father's Name (First, Middle, Last)  18. Mother's Name (Fir												<del></del>	
<u>a</u>	uld be Menta rkad rlc ev	To B	Aloysius	Kalivoo	la				İ	Ма	ry So	ustek					
ary	should and Men a marka umatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z												e, Zip C	ode)	
≥Σ.	and 2 ealth a n 27 le		MS. Lore	tta Kell	um / Da	ughter	309	Will	iam W	Vay S	teven	sville	, MD	MD 21666			
Lechowicz, Skobanie Baltimore, Maryland 21215-0036	Pages 1 nent of He int: If Iten iry or oth			Cremation 3	20b. Place of Disposition (Name of cemetery, crematory or other place)  Teb. 7,					<sup>e</sup> 7,	20c. Location - City or Town, State						
E E	ertme ortan Injur		4 Donation 5 Other (Specify) Chesapeake Cremation 2007 Stevensville, MD  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A.														
_1 88	permit. Depertre Importe any Injt.		17/	wh A.	Vanue	/ M.	013571	Seco	nd Av	renue	SW G	leton Len Bu	rune	, MD 2	ome, 2106	P.A.	
		ai	23a. Part1. Eleter t shock, or hea	he disease, or co int failure. List on	mplications that ly one cause on	caused the deal	1		e of dying	, such as	cardiac or r	espiratory a	rrest,		l Ir	opproximate nterval Between	een
	Physician		Immediate Cause (Final disease or condition resulting in death)  Onset and Dei												ath		
	/Medical Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indised events.														
	xammer	_	Sequentially list co	nditions,	b	HV	W	~ +	~ 1	ر ۸ ، د							
	8 / L =	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate orlying injury	Due to	(or as a consec	pency or):	~ \	_ &	145	5						
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68760,	be e				240.0	(0. 40 4 00.1000	quonico ory.										
387	phys phys s the	Medical			d								74		+-		
Box.	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t ☐ Yes 25 No  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										2:	3d. Date of o		ay Ye	ar
9.	et the by the	چُ ک	9 Unknown'														
Division of Vital Records, P.O	quires their signed tuid be det	٥	Part II. Other signif	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23e. Did tobacco use contribute to the cause of dea				
ပ္ပ	s been si	Completed										24a. Was	an /	24b. Were	autops	y findings av	/ailable
æ	The Ite ha	E											rmed?	prior i death	o comp	detion of cau	ise of
ta	rsician: The law s certificete has t lirector, pege 2 s	0	25. Was case refer	red to medical						26 Place	of Death /	t 🗆 Yes	2 400	t 🗆 Y	es 2	SCN0	
>	ysici is ce direc	To B	examiner? t 🗆 Yes 2	(No	Hospital:	npatient 2□	] ER/Outpati	ent 3 DO	Other		26. Place of Death (Check only one)  1. 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)						
0	ter th		27. Manner of Deat	h 5 🗆 Pending	28a. Date	of Injury oth, Day Year)	28b. Time Injury	of 2	Bc. Injury a			d. Describe I					
<u>.</u>	death. stor: Af the fu	atlc	1 Natural 2 Accident	investigat	ion	,,,	injury	м		es 2 🗌	No						
Divis	al or Attu	Certification:	3 Suicide 6 Could not be determined 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Numb City or Town, State)								Number or	Aural F	Route Numbe	∋ <i>r</i> ,			
	To the Hospital or Atlending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, pege	Medical C	29a. Certifier (Check only one)	Certifying I	Physician: To the aminer: On the land man	e best of my kno basis of examina oner stated.	owledge, dea	ath occurred nvestigation	at the time in my opi	e, date an inion, dea	d place, and th occurred	d due to the at the time,	cause(s) a date and p	and manner place, and d	as state	ed. ne cause(s)	
	To th Within To th	Me	29b. Signature and	itle of certifier	日,			290	. License	number			29d. Date	signed (Mo	onth, De	y, Year)	
			> —	820	4~	m	り	D.	481	001	6		07)	04)	20	107.	
	V		30. Name and addr	ess of person wh	o completed cau	ise of death (Iter	m 23a) (Type	Print)	n'to	)	An	(6)	En.	Ru	rn:	1, 2	1
	Sta	te	31. Date filed (Mon	th Day Year)	32.1	Registrar's Signa	ature	South !	R		U -/			1	,		<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) Day **Physician** Lucas ollise 2.007 Feb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Brighton Garden Assisted Living olumbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 11/9/1921 Year) Months Days Hours Min. 1 □ M 2 □ F 85 230.60.5503 Tennessee Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Md Howard Columbia Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be USA 7110 Minstral Way. Apt 211 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: White Completed by 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 homent of Health and Mental Hygiene. ant: If Item 27 Ia marked other than "natuury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fairfax, Va Public School Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Una Rudder Alvis Jacob Ellis, Sr. 19a. Informant's Name/Relationship (Type. Print)
Michele Smith- Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 la
any Injury or other trau 755 Spring Bloom Dr. Millersville, Md 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory 2/5/2007 4 □ Donation 5 □ Other (Specify) Catonsville, Md 22. Name and Address of Facility Witzke Funeral Homes Inc. 5555 Twin Knolls Rd. Columbia, Md 21045 21. Signature of Funeral Servi Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician & years Coronary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): physician ar the burial-t Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical as NIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) by the a □Yes 2□No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? brillation 3 Probably 4 □Unknown 1 ☐ Yes 2 ▼No heart Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) **市务计计** Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Living 28a. Date of Injury (Month, Day Year) n 24 hours after death.
he Funeral Director: After th
pletely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D.

State Registrar

FEB 0 6 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

,8600

D 56531

Snowden River PKWy, ste 301, Columbia, MD21045

Feb 03, 2007

State Registrar Melissa

31. Date filed (Month

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DHMH 17 Rev 1/2001

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Street

Baitimore

MD

21287-9106

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

camp

06

600 North

gistrar's Signature

amend item 23pt 11 per dec 886.2 6.07 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Meredith Moore 3:23 A January 30,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph's Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 5, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□F 218-24-9633 76 Yrs. Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumatic event, the Modical Exacting fraust its motified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 X No Completed by Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2927 Putty Hill Ave. 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No Navy If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Blue Cross Blue Shield Elementary/Secondary (0-12) 12 College (1-4or 5+) Security N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Moore Mary A. Bussard 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie Moore- Wife 2927 Putty Hill Ave. Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Feb. 3,2007 Parkville, Maryland Moreland Cemetery □Donation 5 □ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Fastians Funeral Chapel & Cremation Services Parkville 8800 Harford Rd. Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ingestive Heart disease or condition resulting in death) muns /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AODM 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificete has l lirector, pege 2 s aspiration pneumonia autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 X R/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours effer of To the Funeral Direct completely filled in by 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 alles Don WD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 6 2007

MOORE

32. Resistrar's Signature

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			1- State of Maryland / Department	artment of Health and Martificate of Death	Mental Hygiene	21111 / 113241
A COMPA	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Day	3. Time of Death
	/Medic		Nina Louise Morgan		February 4,	2007   3:00 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number) 7865 Crilley Road Apt. 482	4b. City, Town, or Location of Death Glen Burnie	40.	Anne Arundel
400	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		217-26-1657 1 M 2 F 75 Yrs.	Months Days Hours Min.	MAR 9, 193	1 Country) WV
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Maryla f sho fed at	ō	MD Anne Arundel Glen Burn:	io		1 □Yes 2√√ No
	r 28a-	irec	10e. Street and Number	10f. Zip Code	10g. Citi	izen of What Country?
	th with	Funeral Director	7865 Crilley Road, Apt. 482	21060		USA
	r dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. V	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by F	1  Never Married 2  Married 1  Yes 2  No If Yes, Give Year or Dates:	1 ☐ Yes 2 ဩxNo Specify:		Specify: White
Maryland 21215-0036	2 hou	ted	15. Decedent's Education 16a. Deced	dent's Usual Occupation		ind of Business/Industry
215	thin 7; e. an "n Medi	ple	(Specify only highest grade completed) (Give life. L	kind of work done during most of work DO NOT use retired)	ang	
21	ed wii ygien ner th it, the	Completed	12 Homema			Home
and	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden	-
Ž	should nd Me mark matic	2	Charles Emerson Smith  19a. Informant's Name/Relationship (Type. Print)  19b. Mailir	Wilda ng Address (Street and Number or Rur	Katheryn ral Route Number, City o	Pritt or Town, State, Zip Code)
Z	nd 2 salth ar 27 ls r trau	1		Coke Ranch Road,	Alexander (	City, AL 35010
re,	of Health a litem 27 is	ı	20a. Method of Disposition 20b. Place of Dispo			ocation - City or Town, State
<u>E</u>	Page ment of ant: If ury or		4 Donation 5 Other (Specify) Metro Cre	ematory, Inc. 2/6/	/2007   Bali	timore, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee H. Williams	Name and Address of Facility Cremation Society 299 Frederick Road	of Maryland	d, Inc.
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TONGUE C.	ANCER	Onset and Death
7	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
	y 12 - 12 m	-	Sequentially list conditions, b.			
3	ufed d ansit	Examiner	Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury that initiated events			
٥,	aw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		resulting in death) Last  Due to (or as a consequence of):			
8760,	ate be hysici the bu	lical	d			
	ertifica ding ph	Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			
Box 6	leath certific attending p	Physician/Med	in the past 12 months?	Ectopic pregnancy Other (specify)	1	23d. Date of delivery  Month Day Year
P.O.	uires that the dean signed by the a	ysi	1 Yes 2 No 9 Unknown			
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ıd	w require been sig should b	ed b	CORONARY ARTERY DISEASE		1 ☐ Yes 2	□ No 3 □ Probably 4 □ Onknown
ecc	e law requ has been je 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>=</u>	The age	Com			performed? 1□ Yes 2□No	- death?
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:	Other:	th (Check only one)	
o	Phys r this raf dir	. To	1	1 3 DOA 4 D Nursing Ho	ome 5 Residence 28d. Describe how injur	
on	Attending r death. ector: After by the fune	tion	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	,	, , , , , , , , , , , , , , , , , , , ,
Division or Vital Records,	or Attencafter death Director:	ifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street ar. City or Town, State	nd Number or Rural Route Number,
	ital or rs afte ral Dir led in	Certification:				
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat a constant of the basis of examination and/or in and manner stated.			
	To the within To the company	N	29b. Signature and vite of pertifie	29c. License number \$29.807		te signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
	J		CARLOS D. ZIGEC, M.D. SUITEIOG, 1401	6 S.CRAIN HWY. (	GEN BURNIE	- MD. 2006/
	Sta Registi		31. Date filed (Month, Day, Year) ' 32. Registrar's Signature	6 SICRAIN HWY, (		
	negisti	œII.	i and a cool bathers by			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Herbert Franklin Moffitt 2007 4 5:49 P Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Towson Baltimore 5. Social Security Number 61.37 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ F 467-03<del>-0137</del> Director 91 May 28 1915 TX Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Roundwood Rd. Unit. 207 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. white Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leroy Moffitt Mattie Rogers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 West University Pksy., Balto., MD Robert Moffitt/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Park Lawndale 2/9/07 Houston, TX 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** phylococcas Sep Sis disease or condition resulting in death) A weeks /Medical Due to (or as a consequence of) Examiner Wests neuman Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I 23e. Did tobacco use contribute to the cause of death? ģ MENO 1 | Yes 2 No 3 | Probably 4 | Unknown Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No funeral director, page 2 s autopsy 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ma) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R Balts and

N. Charles St.

**ORIGINAL** 

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 6 2007

32. Registrar's Signature

# Baltimore, Waryland 21215-0036 M Division or Vital Records, P.S. Box 68760, 84

an	Registrar  1. Decedent's Name (First, Michael Control of the	ddle, Last)	-				2	. Date of Deat		3. Time of De	
cal	Mary Elizab	eth Mayes					J.		30, 2007		
ner	4a. Facility Name (If not institu	_				n, or Location	of Death		4c. County of I		
	Upper Chesape  5. Social Security Number	ake Medica	al Center 7. Age (In yrs. I		Bel A	Air ear   If Under	24 Hrs.   8	. Date of Birth	Harfor	d. Birthplace (State or F	
	215-16-1684 Usual Residence of Decedent	1 □ M 2 🔀 F		Yrs.	Months Da		Min.	(Month, Day,	Year)	Maryland	
	10a. State 10b. Cou	nty	10c. City	, Town or Lo	cation					10d. Inside City I	
Director	Maryland Ha	rford		Joppa	10f. Zip Coo	de		1	0g. Citizen of Wha	1 ☐ Yes 2	
	1008 Brookwoo	d Dr.			2108				USA		
by Funeral	11. Marital Status  1 □ Never Married 2 □ N  3 🎮 Widowed 4 □ Divord	Armed 1 ☐ Ye If Yes,	ecedent Ever in U.S Forces? es 2 X No Give r Dates:		Was Decedent If Yes, specify ( 1 □ Yes 2 ☑			fy Yes or No- can, etc.)		American Indian, White, etc.	
Completed t	15. Dece (Specify only hig	dent's Education ghest grade complete	∍d)	(Give	dent's Usual Oo kind of work do DO NOT use re	one durina mos	st of working		16b. Kind of Business/Industry		
E O	Elementary/Secondary (0-12	2) Colleg	e (1-4or 5+)	Beau	tician				Hair Sal	on	
Be C	17. Father's Name (First, Midd	dle, Last)				18. Moth	er's Name (	First, Middle, i	Maiden Surname)		
2	Harold T. Bi	shop				Gla	adys E	. Timmo	ons	_	
	19a. Informant's Name/Relation								r, City or Town, Sta		
	Alice Rabuck/	Daugnter	20b. P	lace of Dispo	sition (Name o	if i	Dar		aryland 2		
	1 ☐ Burial 2 🔀 Crematio		om State	emetery, crei	matory or other	place)					
	4 ☐ Donation 5 ☐ Othe  21. Signature of uneral Serv		H11		Service 2 Name and Ad				rowson, M	daryland	
	Mussell	Slig			Name and Ad ACCOMAS					land 21009	
iner	23a. Pan1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	List only one cause of	to (or as a consequence of the consequence)	uence of):	Acter Caro		s cardiac or sea	330	est,	Approximate Interval Betwee Onset and Dea	
cal Examiner	that initiated events resulting in death) Last		outcome pf pregnave birth 2 Feta	incy I death 3 [	Ectopic pregn				23d. Date o	*	
	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	4 <u>□</u> Pr	regnant at time of d nknown	eath 5L	Other (specif	,,					
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by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	4⊟Pi 9⊟Ui	nknown				I.	1 🗆 Y	es 2 No 3	□ Probably 4\(\frac{1}{2}\text{Unl}	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Denastruent of Health and Mental Hydiene	rsicia ledic amin
Division or Vital Records, P.O. Box 68760,	ital or Attending Physician: The law requires that the death certificate be executed	in a net occan.  The arter of the attending physician and real blocks. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit

	•	For State Registrar	State of Mar		epartment <i>Certificate</i>			fental Hy	giene Reg. No.	2007	03293
		Decedent's Name (First, Middle, Language)	ast)					2. Date of De			3. Time of Death
Physicia		Edward W.	MacLaren,	Jr.				Month Januar	cy 31	, 2007	11:37 P <sup>M</sup>
/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, To	own, or Lo	ocation of Death			County of Deat	
		Suburban Hosp	ital		Bet	thesd	la		M	ontgome	rv
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last birtl	nday) If Under 1	Year I	f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	9. Birt	hplace (State or Foreign
Director		010-24-5095	1⊠M 2□F	77 Y	rs.	Days	IVIII.	January	29, 1	930 Mas	sachusetts
w w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
f sho	5										1 □ Yes 2 No
the N 28a-	Director	Maryland Montg	gomery	Rockvi	10f. Zip C	ode.			10g Citiz	en of What Co	untry?
with 3a or it be		6717 Old Stage R	oad			208	5.2			ed Sta	
ms 2;	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decede If Yes, specif			ecify Yes or No		4. Race - Ame	
after or ite	큔	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1947-		-		Rican, etc.)		Black, White	
raf", c	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1954	1 ☐ Yes 2	XI NO	Specify:			Specify: W	nite
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/ithin ne. han '	g l	Elementary/Secondary (0-12)	College (1-4or 5+)	Ele	life, DQ NOT use Ctrical	retired). Engi	neer/	5	Comp	uter So	rience
lled v tygie her t		17. Father's Name (First, Middle, Las	5+	<u>cruiter</u>	o (Finat Ministra						
ntal Hed ot ed ot	Be	Edward W. MacLa	•	8. Mother's Nam			Surname)				
d Me nark natic	2	19a. Informant's Name/Relationship		Phyllis d Number or Rui			. T				
d2s than trau		Margaret D. MacL		Road, R							
Heal Heal tem 2		20a. Method of Disposition	aren / Wire		Disposition (Name	40.7	Ti i	Date		cation - City or	
ages ent of rt: If it		1 ☐ Burial 2 M Cremation 3 d 4 ☐ Donation 5 ☐ Other (Spec			r, crematory or oth ry Cremator		Febru	uary	_		Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	··	1 source of the	·						
Perr Imp any onc		1/1/1/1/12	4	M01305	Robert A. 7557 Wisco	Pumph onsin	arey Funei Avenue,	ral Home Bethesda,	/ Bethe Mary	esda-Chev Land 2081	y Chase, Inc. 4-3501
		23a. Part1. Holer the disease, or con shock, or heart failure. List onl	mplications that caused to y one cause on each line	he death. Do n	ot enter the mode	of dying,	such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_a. Ventric	ular Fi	brillati	on					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence o	f):						
Examine	_	Sequentially list conditions,	b. Coronar	#	y Diseas	e					30 Years
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The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	siclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pr	f pregnancy	20				2	3d. Date of del	ivery
deat deatte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		3 ☐Ectopic pred 5 ☐ Other (spec					Month	Day Year
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es thi gned be de	by F	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cau	ise given	in Part I.				the cause of death?
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law las be	Completed							24a. Was		24b. Were au	rtopsy findings available completion of cause of
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this aldir	은	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2.5	patient 3 DOA		4 ☐ Nursing Ho				cify)
Attending Physician: r death. ector: After this certific by the funeral director,	ion	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accident investigation	(Month, Day	Year) 200. In	jury M	c. Injury a Work? 1 □ Vo	t s 2 □ No	28d. Describe	how injury	occurred	
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after after Dire	Certification:	4 ☐ Homicide determine	building, etc.	(Specify)	,			City or To	wn, State)	ramber of the	na riodie Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of e	examination and	death occurred at l/or investigation, i	t the time, in my opin	, date and place, nion, death occur	and due to the	cause(s)	and manner as	stated.
thin 2 the comple	Medical	one)  29b. Signature and title of certifier	and manner state	ed.	29c. l	License n	umber		29d Date	e signed (Mont	h Day Year)
F F F S	_	- D R 1	Chin								
204		30. Name and address of person who	completed cause of dea	ath (Item 23a) /		D1389	<u>۲</u> ۲		reb	ruary !	2007
Jr.		Brian Turrisi, M		,	, Suite	810.	Washing	gton, D.	.C. 2	0037	
Sta	te	31. Date filed (Month, Day, Year)	32. Begistrar	's Signature							
Registr	ar	FEB 0 6	2007	J. St.	Sparks						
HMH 17 Ray 1/2	001		8	•							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer 03294 Certificate of Death Reg. No I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Norma Elizabeth Hunt McCauley 31, 2007 January 10:25 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Chevy Chase Chevy Chase Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 20, 1905

9. Birthplace (State Country)

Minnesota 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 🗶 F Months Days Hours Director 101 Yrs 482-64-1466 Usual Residence of Decedent ir than "natural", or items 23a or 28e-f show the Medical Evandret past be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Kensington Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4101 Glenrose Street 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White Specify: 3X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Activist / Civic Leader Non Profit Organizations 4 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be George Arthur Hunt Mollie Elizabeth Eide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 4101 Glenrose Street, Kensington, Maryland 20895 Mollie M. Dickenson / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 Burial 2 Cremation 3 Removal from State 5 permit. Page Department of Important: If any injury or once. Montgomery Crematorium, Inc. 4, 2007 \*4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Magalette Bays is M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Failure to Thrive /Medical Due to (or as a consequence of) **Examiner** Dementia-End Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed hypothyroidism burial-Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform of Vital 1 ☐ Yes 2**X** No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending death. after death 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I 24 hours a 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20274 February 1, 2007 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710 Bradley Blvd., Bethesda, Maryland 20817 Kirti Vohra, M.D. 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

		-	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death Reg. No. 2 0 7 0 3 2 9 5											
	Physicia	an	Decedent's Name (First, Middle, Last)	ny Sn			2. Date of Deat	h	3. Time of Death 7:43F M					
	/Medic Examin	- 41	4a. Eacility Namo (If not institution, give street and number)	ny, Sr.	4b. City, Town, or	Location of Death	n	4c. County	altimore					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 30	Year)	9. Birthplace (State or Foreign Country) Maryland					
	land ow t		Usual Residence of Decedent         10a. State         10b. County         10c. (	City, Town or Loca	ation				10d. Inside City Limits					
	e Mary a-f sho	ctor	Maryland Baltimore	Towson					1 □ Yes 2 X No					
	with the	Director	10e. Street and Number		10f. Zip Code		11	0g. Citizen of W						
	leath v	Funeral	1551 Putty Hill Avenue  11. Marital Status 12. Was Decedent Ever in	U.S. 13. W	as Decedent of H	<b>o</b> ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race	S.A American Indian,					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	Armed Forces?  1 Never Married 2 Married 1 Married 3 Widowed 4 Divorced 4 Forced 1 Married 1 Married 1 Married 1 Married 5 Married 5 Married Forces?	1953	Yes, specify Cuba □Yes 2🕱 No	Specify:	Hican, etc.)	Specify:	White, etc.					
Maryland 21215-0036	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	16a, Decede	ent's Usual Occup- ind of work done of	ation during most of work l)	ing	16b. Kind of Bu						
121	within and the Mer	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ONOT use retired tions Mai		1	Departm	ent Store					
d 2	I Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)	_   Opera	CTOTIS MAI	18. Mother's Nam								
ylan	Menta Menta arked artic ev	To B	Joseph A. Mur			Mary		belle	Chaffman					
Mar	d 2 sho th and   7 is ma trauma		19a. Informant's Name/Relationship (Type. Print)  Robin Murphy Wife		· ·	and Number or Rui 11 Avenue		; City or Town, S on, Mary						
	s 1 and 2 if Health item 27 other tra		20a Mathad of Diagosition 20h	Place of Disposit	tion (Name of	i			City or Town, State					
<u>m</u>	Pages nent of I ant: If ite ury or or		1 Nation   Display the state   Display the st	ulaney Va Memoria	alley 1 Garden:	s 2-5-		Timoniu						
Baltimore,	permit. Page Department Important: If any Injury or once.		21. Transparation of Furneyal Genice Licensee	ss of Facility Ru k Road	Towson,	Marylan	al Home, Inc. d 21204							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final CORONARY ARTERY DISEASE											
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a cons		AJ A CIPMET I	nel Bany								
4.	Examiner		Sequentially list conditions, Due to (or as a cons	equence of):										
J	uted Insit	Examiner	Sequentially list conditions, it any be first immediate cause. Enter Underlying Cause (Disease or injury that initiated events	equence on.										
, O	icate be executed physician and the bunal-transit	Еха	resulting in death) Last Due to (or as a cons	equence of):										
,0928	cate be	dical	d											
.O. Box 6	The law requires that the death certificate has Leen signed by the attending I hage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No 9   Unknown   9   Unknown	etal death 3 □E	Ectopic pregnancy Other <i>(specify)</i>	1		23d. Date Mor	e of delivery nth Day Year					
٥.	that the	Phy	Part II. Other significant conditions contributing to death but not it	esulting in the und	derlying cause giv	en in Part I.	23e. Did tob	pacco use contr	ibute to the cause of death?					
rds	w requires that the state of th	d be	HYPERTENSION				1 □ Y	es 2□No	3 ☐ Probably 4 XUnknown					
Reco	The law re ate has tee page 2 sho	Completed by	ALCOHOLIC LIVER DISEASE LYMPHOPROLIFERATIVE DISORDER	24a. Was a autops perform	med? Na	Vere autopsy findings available rior to completion of cause of earl?								
tal		Be Co	25. Was case referred to medical		<u> </u>	26. Place of Dea	th (Check only on	2 □ No   1 ne)	Yes 2□ No					
Ž	Physician; this certifical director	To B	examiner? 1   Yes 2   No   Hospital: 1   Nopatient 2	☐ ER/Outpatient		4 LI Nursing H	ome 5 Reside	ence 6 🗆 Othe	er (Specify)					
Division or Vital Records,	nding Pl tth. r: After th e funeral		27. Magner of Death  1 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injur Wor M 1 □	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurr	ed					
Divis	il or Atte after dea I Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building, etc. (Special Could not be determined 28e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A building not be determined 29e. Place of injury - A b	t home, farm, stree	et, factory, office		28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural Route Number,					
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral dir	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)											
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. Licens	e number	2		(Month, Day, Year)					
			Ilm IA Brither M.D.		D51	852		2/1	12007					
_	[AN	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DAUID BRINKER M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204						21204						
	Sta	DAVID BRINKER M.D. 7801 OSEEN DATE												
	Regist	EED O C 2007 Production of the control of the contr												

				rtificate					Reg. No.			
Dhyciaian	1. Decedent's Name (First, Middle, Last)							Date of Dea	ath Day	Year	3. Time of	Death
Physician /Medical	Charles Anthony Man	canto						an	28	2007	12:30	A۱
Examiner	4a. Facility Name (If not institution, give s	treet and number)		4b. City, To	own, or l	ocation o	of Death		4c. C	County of Death	1	
	720 Waters Edge C			Elder						rroll		
uneral	5. Social Security Number 6. Sex	M 2□ F 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Days	Hours	Min.	Date of Birt (Month, Da	y, Year)	Co	nplace (State or untry)	Foreig
irector	216-28-5523 Usual Residence of Decedent	/4	713.				De	ec. 31	, 19.	32 Mary	<i>r</i> land	
à a	10a. State 10b. County	10c. C	City, Town or Lo	cation							10d. Inside Cit	y Limit
tien z.t.s. marked other than "nature", or tems zas or zes-t enow other treumatic event, the Madral Examinar must be notified at To Be Completed by Funeral Director	MAryland Baltimore	Pil	kesvill	_							1 🗆 Yes	20N
be notified	10e. Street and Number		100 / 111	10f. Zip C	ode				10g. Citize	en of What Co	untry?	
4	8809 Stoneridge Cir	Cla APT 104		212	Λο.					ed Stat	•	
niner must Funeral	11. Marital Status	2. Was Decedent Ever in		Was Deceder		panic Orig	gin? (Specify			4. Race - Ame	ncan Indian,	
	1 Never Married 2 Married	1 E-1-103 E - 110	750-	irYes, specify 1 □ Yes 2			i, Puerto Rica	an, etc.)		Black, White		
Exe by	3 ∑XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	960	1∟Yes 2€	- No	Specify:			3	Specify: Wh	ite	
Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual (	Occupat	ion	t of working		16b. Kind	d of Business/I	ndustry	
힏	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	mig mos	or working					
S E	12th		Balt	imore						lities		
Be	17. Father's Name (First, Middle, Last)						r's Name (Fi		Maiden S	Sumame)		
1	Samuel Maranto					Saral	h Citr	ano				
eumatic event, the M. To Be Comp	19a. Informant's Name/Relationship (Typ									Town, State, Z	ip Code)	
ar tr	Kathleen Bartholow			aters I		Ct.		-	, MD	21784		
to To	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	mayal from State	Place of Dispo cemetery, crei	natory or other	er place,		Date			ation - City or T		
n'y	4 ☐ Donation 5 ☐ Other (Specify)	Lak	e View	Mem Pa	ark	1/3	1/2007		Sykes	sville,	MD	
eny Injury or other tre once.	21. Signature of Funeral Service License	Pha	Bi	Name and Irrier-	Address -Que	of Facility	uneral	Home	and	Cremat	ory, P.	Α.
	23a. Part 1. Enter the disease, or complic	ations that caused the de								Lug MD	Approximate	)
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je 💻	Sequentially list conditions, if any, basing to immediate	Due to (or a fa conse	quence of):	1 /	9	1//	pag 10	7			1	-
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the burial-transit		Latell	7 19	pe 2								
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etached for use as: Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic preg					23	d. Date of deli	very	
od for	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Other (spec			<u></u>			Month	Day Y	ear
hys	9 Unknown	9□ Unknown										
		tributing to death but not re	sulting in the u	nderlying cau	se giver	in Part I.		23e. Did to	obacco use	e contribute to	the cause of de	ath?
should t	Coronary no	as assess						1 🗆 Y	es 2D	No 3□Pro	bably 4 🗆 U	nknov
page 2 should be c		- ,						24a. Was	an	24b. Were aut	opsy findings a	vailab
Page 2									med?	prior to c death?	ompletion of ca	use of
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To Be (	examiner?	ospital: 1 Inpatient 2[	☐ FR/Outnatier	at 3□ DOA	Other		rsing Home	1		*10ther (Con-	Niece	
eral		28a. Date of Injury (Month, Day Year)	28b. Time o		: Injury a			Describe h		Other (Specocourred	(y) Resid	enc
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	3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, str	eet, factory, o	office		28f.	Location (S	Street and	Number or Ru	ral Route Numb	oer,
ed in by the funera Certification;	4 [] Horricide	building, etc. (Spec	ciry)					City or Tow	m, State)			
completely filled in by the funeral  Medical Certification:		ician: To the best of my kr er: On the basis of examin	nowledge, death	n occurred at vestigation, in	the time	, date and	d place, and th occurred a	due to the o	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	
completely filled	29b. Signature and title of certifier	and manner stated.			icense							
8	250 Signature and Marian Maria	11.		2	1001130	1	2			signed (Month		
	Mullia	M		U	100	013	5			29-20		
1	30 Name a d address of person who con	npleted cause of death (Ite	23a) (Type,	Print)	77	7 11.	CUTT	0 178	10	11	1202	)
( I .												
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	le 22	4-1	//	1 14	EISICI	25100	U/V 12	11 ~ 2	1208	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year CHARLOTTE F. MISLER 4:55 P M February 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 3/30/1923 Director 219-12-8529 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD BALTIMORE PARKVILLE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2215 A LOWELL GLEN ROAD 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify. à Specify: 3 Widowed 4 □ Divorced WHITE Miskr Char Ltt Baltimore, Maryland 21215-01 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAIR INDUSTRY 12TH GRADE HAIRDRESSER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be MOSES H. JACOBS MARY HUBER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4109 LOCH LOMOND DR. BALTIMORE, MD 21236 JOHN TOSCHES/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LAKEVIEW MEM. PK. 2/5/2007 SYKESVILLE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner that the death certificate be executed and Due to (or as a consequence of): Box 68760, physician s the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 VUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 2 X No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred After t I or Attending I after death. 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

 $YY_X$ State

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year) FEB 06 2007

29b. Signature and t



and manner stated.

**ORIGINAL** 

29c. License number

410301

29d. Date signed (Month, Day, Year)

Lonion, MD 5150A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARGARET C. MEYERS 4, FEBRUARY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE STELLA MARIS TTMONTUM
If Under 1 Year If Under 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2 🛣 F 89 Director 5/25/1917 MARYLAND 216-05-5904 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 ☐ No Directo MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1849 EDGEWOOD ROAD 21234 Funeral USA or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced WHITE 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12TH GRADE HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARCHIBALD CAMERON EDITH HANEKAMP ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health SALLY M. ZELLER/DAUGHTER 8159 GLEN GARY ROAD BALTIMORE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important; If its any Injury or o 1X Burial 2 ☐ Cremation 2/7/2007 MORELAND MEM. PARK HILLENDALE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 22a. Part. Ephr. he disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HOVANCED disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2N No 1□ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 450 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No I Director; 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State

29b. Signature and title of certifier

ARIQ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2300

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

DULDNEY VALLEY RO. TIMONIUM, MD 21093

		1 - For Amend #7 pe	r FH C8	Maryland 6 <b>4 2/1</b> 2/	67 ep	artmen rtificate	t of H e of L	lealth a	and Me	ental Hyg	jiene 	03299
# · .	4	Decedent's Name (First, Middle, La	st)							Date of Dea	th	3. Time of Death
Physic /Medi		JAMES VINC	ENT NASC	HE, III						FEB 2 ,	2007 Year	5:50 A
Exami		4a. Facility Name (If not institution, given	re street and nun	nber)		4b. City,	Town, or	Location			4c. County of Dea	th
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Funeral Director		-	Sex 157 M 2□F	7. Age (In yrs. Ia		If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day March 2	9. Bir 26, 1951 Te	thplace (State or Foreignantry)
land land		10a. State 10b. County		10c. City,	Town or L	ocation						10d. Inside City Limit
witiin 72 hours after death with the Maryland ene. sne. than "natural", or items 23e or 28e-1 show the Modical Exercites the modical Exercites the Modical Exercites the modified at	ţ	Maryland Calver			Dunl	kirk						1 □ Yes 2 XX
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Menta Menta rked rlc ev	ToB	James V. Nasche	Jr.					Vi	rginia	a F. Mo	ore	
z should be to and Mental I	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rural I	Ro <i>ute Number</i>	, City or Town, State,	Zip Code)
and and n 27 In 27 In er tra		Teresa M. Bevard	(sister	)	1204	5 Cent	ury	Mano	r Dri	ve, Dun	kirk, MD 2	0754
of He		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Bemoval from 9	0.00	ice of Dispo metery, cre	osition (Nam matory or o	ne of ther place	Θ)	Dai	te	20c. Location - City or	Town, State
Pages ment of lant: If it jury or o		4 □Donation 5 □Other (Special		Lee		natory				1	Clinton, M	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show amportant: or other traumatic event, the Medical Examiner must be notified all once.		21. Signature of Funeral Service Lice	Bulb	moiz	84 A	<sup>2. Name an</sup> Lexand	<sub>d Addres</sub> Iria	s of Facilit	<sup>ty</sup> Lee 1 y Road	Funeral d, Clin	Home,Inc	6633 01d 0735
Physician   Medical   Medi	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (c	Dement: or as a conseque or as a conseque or as a conseque	ence of):							Interval Between Onset and Death
cate be ex ohysician the buria	dicai		d				_					
ne death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗆 Live bi	come of pregnand th 2 Tetal of ant at time of dea wn	death 3	⊒Ectopic pre □ Other (spe					23d. Date of del Month	ivery Day Year
that the opposite of the oppos		Part II. Other significant conditions	contributing to de	ath but not result	ting in the u	inderlying ca	ause give	en in Part I.		23e. Did tob	pacco use contribute Id	the cause of death?
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w requir s been si should	Completed									24a. Was a	n 24b Were au	itopsy findings available
The lay	mo									autops perform	y prior to oned? death?	completion of cause of
an: tifica tor, p	8	25. Was case referred to medical						26 Place	of Death /	1 ☐ Yes 2 Check only on	No 1 □ Yes	2□ No
Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 🏋 🏋 No	Hospital:	patient 2 E	R/Outpatier	nt 3 DO	A Othe				ence 6 □Other (Spe	cify)
ding Physician: The I h. After this certificate ha funeral director, page		27. Manner of Death  XXXNatural 5 ☐ Pending	28a. Date o	f Injury 2 n, Day Year)	28b. Time o	f 28	Bc. Injury Work				w injury occurred	
Attending r death. ector; After oy the fune.	Certification:	2 Accident	n			М		/es 2 □ I	No			
or Attendent ter death irector; n by the	T I	3 Suicide 6 Could not be determined	e 28e. Place buildin	of Injury - At hom g, etc. (Specify)	ne, farm, st	reet, factory,	, office		28	f. Location (St. City or Town	reet and Number or Ru n, State)	ıral Route Number,
within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier 1	ysician: To the	best of my know	ledge deat	h occurred a	at the tim	e, date an	d place, and	d due to the ca	ause(s) and manner as	stated.
To the Hospital or within 24 hours afte To the Funeral Director Completely filled in the complet	Medical	one)	and mann	er stated.					53601160			
5 1 N 00	-	29b. Signature and title of certifier	2				License				9d. Date signed (Monti	
1		re ran	(~				28352				Feb 2, 200	/
)		30. Name and address of person who										
200		Krishan Mathur, 1 31. Date filed (Month, Day, Year)	1D P.O.	BOX 1703	B, Lal	Plata,	MD	2064	46			
Sta	ite	FFR 0 6 201		gistrar's Signatu	Ana	A						

DHMH 17 Rev 1/2001

			1- For State of Maryland / Dep Registrer Ce	artment of Health and M	ental Hygien	ZUU1 03300								
in.	Physicia		Decedent's Name (First, Middle, Last)     Eleanor May Neumayer		2. Date of Death Month Di	3. Time of Death 30, 2007 5:04 A <sup>M</sup>								
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number)  Wilson Health Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death  Gaithersburg  If Under 1 Year   If Under 24 Hrs.		c. County of Death  Montgomery  9. Birthplace (State or Foreign								
	Funeral Director		5. Social Security Number 221–18–2018 6. Sex 1 $\square$ M 2 $ mathbb{N}$ F 7. Age (In yrs. last birthday, 96 Yrs.	Months Days Hours Min.	August 20, 1	910 Nebraska								
	the Maryland 28e-I show notified at	ector	10a. State 10b. County 10c. City, Town or L  Maryland Montgomery Gaithers  10e. Street and Number		10a. C	10d. Inside City Limits  1								
2	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if them 27 le marked other then "natural", or items 23e or 28e-f show important: if them 27 le marked other then "natural", or items 23e or 28e-f show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	P.O. Box 83956	20883  Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Un	ited States  14. Race - American Indian, Black, White, etc.  Specify: White								
20-6131	within 72 hou ene. then "natura he Wadden!	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) ochemist	16b.	Kind of Business/Industry  Research								
ylalıa 6	ould be filed I Mental Hygi tarked other tatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert Neumayer	18. Mother's Name Harriet	(First, Middle, Maide Mary Cler	n Sumame) ndenin								
ב ע	s 1 and 2 sh of Health and Item 27 le m other traum		Timothy E. Clarke/Attorney 30  20a. Method of Disposition 20b. Place of Disposition	Timothy E. Clarke/Attorney  30 Courthouse Square #200, Rocky  31 Disposition  1 Disposition  20b. Place of Disposition (Name of commetery, crematory or other place)  20c. Loc  20c. Loc										
	permit. Peges Department of I Importent: If Its eny injury or o		4 Donation 5 Other (Specify) Montgamer		07 Βε	ethesda, Maryland								
(15),2 東	The law requires that the death certificate be executed The law requires that the death certificate be executed The Discourage 2 should be detached for use as the burial-transit use Inc.	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death One Collection								
.O. DOX	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year								
COLUS, T	equires that sen signed b ould be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the any feet tension. Symmetrics	Lisuse	23e. Did tobacco	use contribute to the cause of death?  2								
אוומו אפני	n: The law r ficate has be or, page 2 sh	e Completed	Scherdelma, Carmanyarte. Concernoma, bresst. Anume 25. Was case referred to medical	Lychemic descer	24a. Was an autopsy performed?									
5	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ToB	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation  Hospital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) Injury		ne 5 Residence									
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	the Hosi hin 24 ho the Fune mpletely f	Medicai	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurred 29c. License number	ed at the time, date an	s) and manner as stated.  Indiplace, and due to the cause(s)  ate signed (Month, Dey, Year)								
	or viit		29b. Signature and title of certifier  14. Robert Suise Conduction  20 No. 10 10 10 10 10 10 10 10 10 10 10 10 10											
	17		30. Name and address of person who completed cause of death (Item 23a) Type  14. ROSERT BIRSCHAHH, MM  31. Date filed (Month, Day, Year)  32. Registrar's Signature	641THERSBL	HE (VI	20877								
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	sele!										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend items 7,20h per fh 9864 2-6-07 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OWAR 4. County of Death DRUGA V /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A ohns 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 64 Days 459.62.8916 1**X**M 2□F Months TXDirector 01.10.1943 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore 1 es 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? E. Belvedere Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2000 PMo Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Government 12th grade Styears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Catherine Howard L. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun 301-5 Balto. MD 21212 Belvedere Avenue Ozbon Patricia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02 1 ☐ Burial 2 Cremation 3 ☐ Removal from State greenmount Crematory 01:05.07 Bautimore, MP 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of acility tuneral sentices Lugan C. Grene tuneral sentices 405 York Koad Baltmore MiD 21212 21. Signature of Funeral Service Licensee Eur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** WEEKS disease or condition resulting in death) neumon A /Medical Due to (or as a consequence of) Examiner 0011 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed After this certificate 1□ Yes 2 No 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 | Yes 2 | No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 Yes 2 No death. within 24 hours after death To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RFS - 000 MEDIUL BOCTOR. .30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 BAltiMURE, MARY lAND DURAND N. WOIFE ANIEL 600 Day, Year) 31. Date filed (Month, Registrar's Signature State 06 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bay Month **Physician** 2007 ear Michael Joseph O'Connell February 1:05 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing Center Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min 1⊠M 2□F 043-14-2677 83 Director February 18, 1923 Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13303 Oriental Street 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No World If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: War II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy Michael O'Connell Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thelma J. O'Connell / Wife 13303 Oriental Street, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Silver Spring, February 8, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Maryland 22. Name and Address of Facility Robert A Rockville Inc. 300 West M Rockville, Maryland 20850 A. Pumphrey Funeral Home, Montgomery Avenue 21. Signature of Funeral Service Licenses M01433 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Dementia attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' After this certificate 2 No 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺ No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 🕅 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident i Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30132 February 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14812 Physicians Lane, #161, Rockville, Maryland 20850 Cosh, M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			State of Maryland / Department of Health and M	-	_	•
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Department	any i		Mullyne D. Nowy 4600 LIBERTY HE			HOME 21207
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Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending ph	completely filled in by the funeral director, page	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one) and manner stated.	rred at the time, da	te and place, and o	lue to the cause(s)
To t With	60 E	Σ	29b. Signature and title of certifier 29c. License number		d. Date signed (Mo	
	n	-	Esti Schelselin MD AU41764355175	7.3	2/2/07	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ESTEBAN SCHABELMAN MD 10 N. Creeve St. Bult.	imore Mi	0 71701	
	Sta	te	ESTEBAN SCHABELMAN ND 10 N. Greene St. Bult.  31. Date filed (Month Pay Year) 2007  22. Registrar's Signature	1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 200<sup>Year</sup> Charles J. Prescimone Jr. Feb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 403 Beechland Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 7, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□ F Months 213-58-3928 Maryland 55 Director Usual Residence of Decedent death with the Maryland 10a. State 10b Count 10d. Inside City Limits 10c, City, Town or Location 28a-f show Pages 1 end 2 should be filed within 72 hours after death with the Maryla ment of Heelth and Mental Hygene. The waste as 28e-1 show and if if the marked other than "natural", or Items 23e or 28e-1 show ury or other traumatic event, its Medical Exercities must be notitied at Baltimore Essex MD 1 ☐ Yes Ž ☐ No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 7 Lindsey Court 21221 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4or 5+) Maryland 2yrs Correctional Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Prescimone Sr. Antonette Berardinelli 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lindsey Court Baltimore MD 21221 Barbara A. Prescimone 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H important: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 2-5-07 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Surature of Funeral Service License -01 Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease or construction shock, or heart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner secuence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 2 No 2 1 No 1 Tyes the Hospital or Attending Physicien: Be 25. Was case referred to predical 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Moth (25 House 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred After atural Iniun 5 Pending s after death.
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of in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

32 Registrar's Signature

**ORIGINAL** 

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 31, 2007 7:45 A James Emanue1 Papademetriou January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1 M 2 □ F Hours Director 56 216-52-1501 July 6, 1950 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 No Director Maryland Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12702 Ponderosa Lane 21057 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Club Management <u>General Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be 2 Emanuel Pappas Pauline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra 12702 Ponderosa Lane, Glen Arm, MD Teri Papademetriou/Wife 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2/5/07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 24. Signature of Furlant Sarvica Lidensee Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary 23a. Part / Enter the disease, or complications that cosho, or hear failure. List only on-cause on e used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ich line. Approximate Interval Between Onset and Death Immediat Caus Final disease o on resulting in death) **Physician** static lars rizeta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Was autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

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31. Date filed (Month, Day, Year)

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gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

Charles St. Balts and 21204

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

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To the Hospital or Attending PI
within 24 hours after death.
To the Funeral Director: After the

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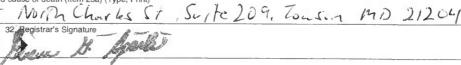
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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D006119

29d. Date signed (Month, Day, Year)

FC6.3.2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 26, 2007 19:15 Visvaldis Plostnieks /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1ॼM 2□F Director June 4, 579-42-5695 1931 Latvia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f st any injury or other traumatic event, the Medical Examiner must be notified one. 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Crail Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2□No Korean 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Conflict 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Building Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fricis Plostnieks ပ္ Late Dzerve 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary T. Nathan / Friend 7101 Crail Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rock Creek Cemetery 2007 Washington, 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, I 7557 Wisconsin Ave., Bethesda, MD 20814-3501 21. Signature of Funeral Service L M00896 23a. Part1. Enter the sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f lure. Just only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUN G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and resulting in death) Last Due to (or as a consequence of): 68760, physician certificate be Physician/Medical Box 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for o 9□Unknown 9 Unknown ۵ The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy certificate 1□ Yes Vital 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident **Division** or Attending 5 Pending investigation Injury s after decral Director; After 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Alpa M.D. D-27 660 0/ 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) ALPANA GOSWANI 11119 Rockville Pike #G100, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, 2007 Dond SAL \_Month **Physician** FILIS 9:15P M Clarena Ebron "/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 110ms) Westminst (2moll HOSPITEI can If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**№** M 2□ F 87 31/ MARYLAND Director 218-01-5367 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No FINKSBURG Director MD CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2013 OLD WESTMINSTER PIKE 21048 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after cand Mental Hygiene.
Is marked other than "natural", or iten ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) he YARDMASTER RAILROAD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi lealth and Mental F SMTTH ORLANDO W. POND JENNY L. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 4 8 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai DORIS M. GREENE - DAUGHTER 2013 OLD WESTMINSTER PIKE, FINKSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State EVERGREEN MEM.GARDENS 2/8/07 FINKSBURG, MD Donation 5 Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. signature of Funeral Service Licensee MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) everon Days. **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or userlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform 2 No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27 Mann f Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred atural **Division** (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State Registrar

DHMH 17 Rev 1/2001

795 Sporer Are.

29c License number

000599443

29d. Date signed (Month, Day, Year)

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and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day,

FEB

State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician PAULINE DUNN PETERSON JANUARY 2301 30, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year f Under 24 **Funeral** Days Hours 1 □ M 2 🛛 F 214-16-0969 81 Director 11/27/1925 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or than "natural", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD CARROLL WESTMINSTER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 ST. MARK WAY, APT. 306 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION 12 PAYROLL CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN MYRTLE V. GRABILL ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 8 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s if Health an item 27 is ROBERT V. PETERSON-HUSBAND 201 ST. MARK WAY, APT.306, WESTMINSTER, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
importent: if ite
ony injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) EVERGREEN MEM.GARDENS 2/3/07 FINKSBURG, MD ignatur of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NTRACEREBR HEMORRHAGE 24 HOWES /Medical Due to (or as a consequence of): Examiner PERTENSION STEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ MELLITUS 2 -No 3 Probably 4 Unknown 1 Yes Completed ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 2 100 Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA To the Hospitel or Attending Physilin 24 hours after death.

To the Funerei Director: After the completely filled in by the tuneral 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier adu Nafarma WVdc 00018200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PONLE RD WESTMINSTER MUD 21157 CHITRACHEDU NACHWA MD 700-A 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0 6 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 4, John A. Romoser HEBRUARY 2007 9:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2 □ F 214-36-8804 67 Yrs. Director 7/9/1939 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 28a-f sh notified 1 ☐ Yes 🏵 No Funeral Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? h and Mental Hygiene. 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 9909 Harford Rd. 21234 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 200 XNo Specify: Specify: White \$ % Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Financial Manager Panasonic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be t nent of Health and Mental I George H. Romoser Sr. Katherine Ann Nevin ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 Is any injury or other trau Margaret Hart 9911 Harford Rd. Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State February 7, 4 Donation 5 Other (Specify) 2007 Timonium, MD Memorial Gardens 22. Name and Address of Facility Evans Funeral Chapel And Cremation Services Juneral Service Licenses 21. Signature 8800 Harford Rd. Parkville, MD34 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTROINTESTINAL BLEEDING /Medical Due to (or as a consequence of) Examiner VASCULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit WEGENER SYNDROME Due to (or as a consequence of) Box 68760. Physician/Medical as th IE EEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 TYes 2 TNo been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has treetor, page 2 s autopsy performe 1∐ Yes 2 X No or Attending Physician; 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Tyes 2 TNo Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

29b. Signature and title of certifie

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ABDALLAH

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

D 17695

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year A M Alan Feb 2, 1:15 Haines Raynor 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6206 Buttercup Lane Upper Marlboro Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days 577 54 1734 Director 68 April 7, 1938 Washington DC Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Mary1and Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n death with 6206 Buttercup Lane Funeral 20772 United States
14. Race - American Indian,
Black, White, etc. ural", or items 2 I Examiner mur 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 TYes 2 No If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: er than "natur , the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 Pepco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic ever William A. Raynor ၉ Madalyn R. Haines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Raynor (Wife) 6206 Buttercup Lane, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 5, 2007 Lee Crematory Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licen mo1284 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** carcinomo disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1°Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of cate has by page 2 s death? 1 ☐ Yes 2□ No 1□ Yes 2√No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home To Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident To the ruceprose after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 046478

Registrar

State

surratts Rd. Clinton MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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FEB 0 6 2007

31. Date filed (Month, Day, Year)

Patel, MD

7501

32. Registrar's Signature

			For State Registrar	State of M	Marylan	-	artmen rtificate			and M		giene) Reg. No.	07	033	312
	Physicia	an	1. Decedent's Name (First, Middle,								2. Date of De Month	ath Day	Year	3. Time of	
	/Medic	al	RUTH ROBERT		e)		Ab Cibr	Town or	Location of	f Doath	14UAB37		Loo 7	6:15	A M
1	Examin	CI I	4a. Facility Name (If not institution, BALT'I WORE WAS)			CCNTCO			BURN			HUMA		UNDEL	
	Funeral			6. Sex 7. A		last birthday)	If Under	1 Year	If Under		8. Date of Bir (Month, Da	th	9. Birth	nplace (State ountry)	or Foreign
Н	Director		219-30-6642	1 □ M 21X F	74	Yrs.	Months	Days	Hours	MIII.	11-18			ME	)
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside C	ity Limits
	Maryla f shor	ō		runde1		len Bu								1 □Yes	2X No
	28a-	rect	10e. Street and Number	II direc i		ICII Du	10f. Zip	Code				10g. Citizen o	of What Co	untry?	
	h with	a D	123 Wilson Blvd	ι.			21	061				U.S.A.	1		
36	172 hours after death with the Maryland "naturel", or iteme 23a or 28a-f show folcal Evaninar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2⊠ Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force ed 1 Tes 2 Fif Yes, Give Year or Dates	s? ∐No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto l	city Yes or No Rican, etc.)	14. R B Spec	lack, White	ncan Indian, e, etc. white	
Ö	2 hou		15. Decedent	s Education		16a. Dece	dent's Usua kind of wo	al Occupa	ation	t of worki	na	16b. Kind of	Business/	Industry	
21215-0036	within 7 ene. than "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-40	or 5+)	life.	DO NOT us	se retired	) )	o work	g	Motor			
7	be filed within 72 ho ntal Hygiene. od other than "natur event, tre Medical		12 17. Father's Name (First, Middle, L	acti		Super	visor	T	18 Mothe	ar's Name	(First Middle	Admini , Maiden Sum		tion	
and	ntal H ed off	Be	William James H								Culpe		La.1110)		
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	ှင	19a. Informant's Name/Relationsh			19b. Maili	ng Address	(Street a				er, City or Tov	vn, State, ž	Zip Code)	
	27 in		Mr. Edward Robe	erts, Jr./	son	283	7 Mau	dlin	Aver	ue;	Baltime	ore, MI	2123	30	
ore,	ges 1 ar it of Hea if item or otha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from Sta		lace of Dispo emetery, cre	osition (Nar matory or d	ne of ther plac	e)	C	ate	20c. Locatio	n - City or	Town, State	
Ĕ	Pages ment of h ant: if ite		4 □ Donation 5 □ Other (Sp	ecify)	Che							Steven			
Baltimore,	permit. Pages Depertment of Important: If any injury or any injury or		21. Signature of Funeral Service L	1 wint	1014	79 1	Seco	nd A	ve SW	; G1	en Bur	n Funer		51	
П			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus only one cause on each	sed the deat line.	h. Do not en	ter the mod	le of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approxima Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. A21	12trole	ens	7.							45 mi	netos
	/Medical Examiner	jr.	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	at a conseq	7	disa	عدن						15 40	in
	te be executed ysicien and The burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a conseq	177	(V)								
68760,	# × #	Cai		d											
Box	The law requires thet the death certifica sie has been signed by the attending ph page 2 should be detached for use es if	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fete tat time of d	death 3	⊒Ectopic p ⊒ Other (sp						Date of del Month	ivery Day	Year
ds, P.O.	uires thet t i signed by Id be detai	þ	Part II. Other significant condition	ns contributing to death	n but not res	ulting in the u	underlying o	ause giv	en in Part I			tobacco use c			
Records,	he law requir s has been si ge 2 should	Completed										ormed?	prior to death?	itopsy findings completion of	available cause of
Vital	an: T tificet tor, pa	Be Co	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes		1 🗆 Yes	2 No	
Ž.	Physician: this certificated rail director, I	ToB	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	atient 2	ER/Outpatie	nt 3□ DC	Oth Oth	er: 4 □ Nu	ursing Ho	me 5□Res	idence 6 □0	Other (Spe	cify)	
ion of	Jing After fune		27. Manner of Death 1 ଔNatural 5 ☐ Pendin 2 ☐ Accident investig		njury Day Year)	28b. Time of Injury	of A	28c. Injun Wor 1 🔲	yat k? Yes 2 □		28d. Describe	how injury oc	curred		
Division	al or Atte s efter de il Directo id in by th	Sertific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289. Place of	Injury - At h etc. (Specia		treet, factor	y, office			28f. Location City or To	(Street and Nu own, State)	imber or Ri	ura I Route Nui	mber,
	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	Medical Certification;	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the be Examiner: On the basis and manner	s of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time	cause(s) and , date and plac	manner as ce, and due	s stated. to the cause	(s)
	To th within To th	M	29b. Signature and title of certifier				29		e number			. \		h, Day, Year)	
			(Emrolina)	( coordian)	MD			000	26.5°	+14		Fapma	ed 5	, 5007	τ
-	10		30. Name and address of person	/ _ 1								-			
	1		GUILLERHO JOS 31. Date filed (Month, Day, Year)		istrar's Sign		JATIS	DISI	UE, G	CEN	BURD	IE, HD	2010	0	
	St Regist	ate rar	31. Date filed (Month, Day, Teal)		Lance of Origin	M. A	made s								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 0331 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Hazel Miller Reynolds February 1, 2007 00:10 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 1915 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Director 216-40-6176 91 May Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 😿 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 15217 Emory Lane Itema 23a 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Ā 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within intent of Health and Mental Hyglene. Int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be ပ Emory Hoge Miller Matilda Eliza Vaughan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any Injury or other trat once. Robert V. Reynolds / Son 568 Laurel Road, Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 2007 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRobert A. Pumphrey Funeral Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850 Funeral M01473 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Kneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATBIAL FIBBILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should MYOCARDIAL INFARCTION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an hes autopsy performed? CORONARY Division of Vital ARTERY 1 Yes 2√No funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To this 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 Yes 2 No 2 Accident the 24 hours after deat • Funerel Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D00616 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20832 18101 Tobert Inve, olnee 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB Registrar 6 0 38000

		For State Registrar	State of Marylan		artment of F rtificate of			ienė () () 7	03314
Physici /Medi		Decedent's Name (First, Middle, Last)  Lo	uise M. Roth				2. Date of Deat Month Februar	Day Year	3. Time of Death 6:50 P
Examir		4a. Facility Name (If not institution, give st Wilson Health Care	reet and number)			r Location of Death nersburg		4c. County of Dear	h
Funeral Director		190-18-0969	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 4,	Year) 9. Birt	hplace (State or Foreign untry) nsylvania
Maryland f show	lor	Usuel Residence of Decedent  10a. State 10b. County  Montal and Montacomore		r, Town or Lo		1240			10d. Inside City Limits 1X Yes 2 □ No
with the I	I Directo	Maryland   Montgomer 10e. Street and Number 301 Russell Aven	-	G	aithersbu 10f. Zip Code	20877	11	Og. Citizen of What Co	,
15-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show calcule to arriver must be notilised at	by Funeral		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	ncan Indian,
- c * 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of wor d)	king	16b. Kind of Business.	Industry
Iand 212  uld be filed within fental Hygiene.  rked other then tic event, the M	To Be Co	17. Father's Name (First, Middle, Last) William M. Stils	on	ASSI	stant Tre	18. Mother's Nan	ne (First, Middle, M		d Hospital
		19a. Informant's Name/Relationship (Type Jacqueline M. Paul 20a. Method of Disposition	/Great Niece	4024	3 Feather	bed Lane,	Lovetts	, City or Town, State, . Ville, Vir. 20c. Location - City or	inia 20190
Baltimore, permit. Pages 1 ar Department of Hea Importent: If Item any injury or othe		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Park	Memorial  Name and Addre	20	6, 07	Rockville,	Maryland
Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death e cause on each line.	Pa	ODERT A.  OO West Moter the mode of dying	Pumpnrey ontgomery ng, such as cardiac	Ave., Roc or respiratory arre	Home/Rock ckville, MI	Onset and Death
68760, fleate be executed sphysicien end is the burial-transit a	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						wech
BOX 6 ath certifi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	ic. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3[	□Ectopic pregnanc □ Other (specify) _	У		23d. Date of de Month	livery Day Year
rds, P.O. I quires that the de n signed by the a uld be detached f	ğ	Part II. Other significent conditions conf	inbuting to death but not resi	ulting in the u	underlying cause giv	ven in Part I.		bacco use contribute le	o the cause of death?
	Completed						24a. Was a autops perform	med? prior to death?	utopsy findings available completion of cause of
Vital Filicien: The certificate	Be	25. Was case referred to medical examiner?	ospital:		O#	nor /	ath_(Check only on		
Division of Vital t or Attending Physicien: 3 after death. Director: After this certifical I in by the funeral director, p	tlon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju	4 Nursing H		ence 6 Other (Spe	cify)
Division of Vita within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of				28l. Location (St City or Town	treet and Number or R n, State)	ural Route Number,
DIVI To the Hospital or Al within 24 hours after of To the Funerel Direct completely filled in by	edical C		ician: To the best of my kno er: On the basis of examina and manner stated.						
To the within 2 To the complete	M	29b. Signature and title of certifier	Mari		29c. Licens	70178		Februry	n, Day, Year)
15		30. Name and address of person who con	npleted cause of death (Item		Print) Sell A	ve. 6 =	ithershu	ig Md.	

32 egistrar's Signature 31. Date liled (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 ORIGINAL

			1 - For Amend #18 Registrar	State of Ma Per FH go	364 Z	15/0 Ce	artme rtifica	nt of H	lealth a Death	and M	ental Hy	giene Reg. No.	2007	03315	5
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Day	/ S Year	3. Time of Death	
45	/Medic		Harlan W. Rines								Month Februar			9:50 а.м	
	Examir	er	4a. Facility Name (If not institution, give		1100			, Town, or kvill	r Location o	of Death			County of Deat		
	Funeral		Montgomery Hospice  5. Social Security Number 6. Se			last birthday)		er 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birt	hplace (State or Foreign	
	Director		220-38-1622	⊠M 2□F	66	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept. 1	y, Year) 1, 1	.940 New	untry) York	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	naction							404 1-11-05 11-5	
	faryla shov ed at	ō				kville								10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	the N 28a-1 notifi	Director	Maryland Montgome  10e. Street and Number	iry	ROC	KVILLE		ip Code				10a. Citi	zen of What Co		
	3a or		12512 St. James Ro	nad				350					ed State	1	
	death	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	.S. 13.			lispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Ame	rican Indian,	
36	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 [★Yes 2 ☐ ] If Yes, Give Year or Dates:			1 ☐ Yes		Specify:		mouri, etc.,		Specify: Wh		
9	2 hour		15. Decedent's Ed	ucation	1,50	16a. Dece						16b. Ki	nd of Business/		
215	within 72 ene. than "na he Medi	plet	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	i+)	life.	DO NOT	use retirec	,	t of workir	ng			•	
21	filed wit Hygiene other tha	Completed		4		Gener	al E	ngine						vernment	
nd	be filk ntal Hi d oth eveni	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Surname)		
ryla	2 should be f and Mental I Is marked of raumatic eve	유	William H. Rines  19a. Informant's Name/Relationship (7	Firma (Print)		10h Maili	na Addre	(C44					r Town, State, 2		_
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es once.		, ' '	Vife								-	aryland		
ē,	s 1 ar of Hea Item other		20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Na	ame of		eb.		-	cation - City or		_
Ë	Page nent o		1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		1	lawn Me	_			2007		Rocks	ville. N	Maryland	
Baltimore,	permit. Departn Importa any inju		21. Signature of Funeral Service Licen	see		RC2	2. Name	nd Addre					lle, Inc.		
_	99789		7		M008	96 BO	0 W.	Mont	gomer	y Av	e., Ro	ckvi	lle, MD	20850-2805	j
	Physician		23a. Part1. Enter the disease, or comp shock, or heart ailure. List only of Immediate Cause (Final disease or condition	olications that caused one cause on each lir a. Metasta						cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):									
	**	er	Sequentially list conditions, if any, leading to immediate cause Enter Underlyin Gause (Disease or injury	b. Due to (or as	a conseq	uence of):									—
	icate be executed physician and the burial-transit	Examiner	that initiated events	C											
30,	cate be executed ohysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):				_					
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9 xc	eath certific attending p for use as	/Me	IF FEMALE:	23c. If yes, outcome	pf pregna	ancy							23d. Date of deli	ivon	
, Box	the death certific y the attending p iched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic ⊒Other (		/				Month	Day Year	
P.0	that the d ed by the detached	Phys	9 Unknown	9□Unknown							1				
	es ign be	by	Part II. Other significant conditions of	ontributing to death be	ut not res	ulting in the u	ınderlying	cause give	en in Part I.					the cause of death?	
Sor	w requii been s should	Completed							-		-		1	obably 4 Unknowr	_
Rec	ne law has l	ldm									24a. Was autoj		24b. Were au prior to death?	topsy findings available completion of cause of	à
ē	(0 -		25. Was case referred to medical							45	1□ Yes	2⊠ No	1 ☐ Yes	2 ☐ No	
₹		o Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatie	nt 3□[	Oth			(Check only o		6 🖾 Other (Spec	Inpatient	_
0	g Physer this	n: To	27. Manner of Death	28a. Date of Inju	ry	28b. Time o		28c. Injur Worl			8d. Describe			Hospice	
ion	Attending r death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investigation		y rear)	Injury	М		Yes 2 □	No					
Division or Vital Records,	or Atter de titer de Directe in by ti	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju- building, etc	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, facto	ry, office		2	28f. Location (3 City or Tox	Street an vn, State	d Number or Ru	ıral Route Number,	
Ω	pital curs af	O	00- Cartifica 157 Cartifician Dis	unicione To the book	-6 les-		Ab	al = 1 11 = 1°		al alasa					_
	e Hospital 24 hours a Funeral etely filled	Medical	29a. Certifier 1 🔀 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	f examina	tion and/or in	nvestigation	on, in my c	me, date an opinion, dea	nd place, a ath occurr	and due to the ed at the time,	date and	and manner as place, and due	stated. to the cause(s)	
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Dat	te signed (Monti	h, Day, Year)	
			Kynthia m.	) Delle	we	000		HOC	0580	32		2	-5-200	7	
	9X1		30. Name and address of person who o	completed cause of d	eath (Iten	n 23a) (Type,	, Print)				l_			20855	
	0.		Cynthia M. William				Hos	pice,	, 6001	l Mun	caster	Mil	1 Rd., 1	Rockville,	MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ars Signa	ature	back	1							

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State Registrar 31. Date filed (Month, Day, Year) FEB 0 6 2007

FRANKEL

R.

NEAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Spell

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200-

MARYLAND 21204

07-00939	
Gregory Ridgway	

State of Maryland	Department of Health	and Mental Hygiene

		1- For State Registrar	-	Ce	rtificate	e of i	Death		,	5	Reg. No	. 21	10	7 033
Physicia	ın/	Decedent's Name (First, Middle,Last)						2	2. Date of De Month		Yea		3. Time of Death	
Medical Examir	1er	Gregory Ridgway  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death							f Dooth	Month February		007 Ic. County o	f Dooth	1730 hrs
	١	St. Agnes Hospital	n, give street and ni	imper)		44	Balitmore	ocation o	r Death			ic. County o	i Death	
Funeral	7	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	ıy)	If Under 1 Year	If Under	r 24Hrs.	8. Date of E	irth(MN	A/DD/YYYY		place (State or
Director	1	215-90-0866	1 <b>XX</b> M 2 F		13	Yrs.	Months Days	Hours	Min.	June	28,	1963	Foreign Cou	ntryMaryland
	_ L	Usual Residence of Decedent											<u> </u>	
w any		10a. State 10b. County		10c. Cit	y, Town or I	ocatio	n							10d. Inside City Limits
land f show	5	Maryland   Balti	more	Ark	outus									1 Yes 2 X No
ith the Maryland 13a or 28a-f show any notified at once.	Director	10e. Street and Number					10f. Zip Code					tizen of Wh	at Count	ry?
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e, M l and 2 Health litem 2 rr traun		20a. Method of Disposition				isposit	on (Name of cem			Date		Location -	City or T	own, State
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Baltimore, permit Pages 1 a Department of He Important: If ite	1	21. Signature of Funeral Service	Licensee	-		22 No	me and Address	of Facility			Home at MMP, INC.			
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x 68 th certi	icia	past 12 months?	4 Preg	nant at time of o	leath 5	-	er (Specify)			,				.,
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ision Attendin r death ector: A	tio	1 Natural 5 Pend		2.2.2007	unk		1 Y	es 2 X	No	unk				
Division of Vital Records, la to Attending Physician: The law requir rs after death al Director: After this certificate has been siled in by the funeral director, page 2 should be	ifica			ce of Injury - At	home, farm	, street	, factory, office bu	uilding, etc	: 2	28f. Location or Town,	(Street	and Number	r or Rura	al Route Number, City
DIVI Spital or fours afte	Certification:	4 Homicide	rmined (Specify	house	e					Baltim		MD	GIOL	ia Ave.
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifind 24 hours after death the Funeral Director: After this certificate has been signed by the attending repletely filled in by the funeral director, page 2 should be detached for use as			Fier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
/ P F P P and manner stated.														
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mon.  O.C.M.E.  February 4, 2007									n, Day, rodr)				
	-	30. Name and address of person who completed cause of death (Item 23a)												
1		Margarita Korell MD.	Assistant Me	•	,	I1 Pe	enn Street, Ba	ltimore	, MD 2	1201				
	ate	31. Date filed (Month, Day, Year)	32. F	gistrar's Signa	ture	1								
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Differ 1/2	001		-		ORIG	INAL								

OCME 2006

State of Maryland / Department of Health and Mental Hygiene 17 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** January 31, 2130 P M Gertrude S. Schultheis 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 20, Birthplace (State or Foreign Country) Year) 1918 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2【XF 88 Maruland 220-09-4785 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Items 23s or 28s-f show instruct be notified at 1 ☐ Yes 2 ☑ No Completed by Funeral Director Maruland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9810 Richlun Drive 21128 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. the Medical Exeminer 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: if item 27 is marked other tha any injury or other traumatic event. Ital 2005. Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edwin Harrison Florette Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Borgia Ct., Parkville, MD Mr. Don Schultheis 21234 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Timonium. Maryland 4 Donation 5 CXOther (Specify) Entombment Dulaney Valley Maus. 2/5/2007 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Fineral Service Licensee 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardi Physician /Medical Examiner herosclenda D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien end for use as the burial-transit The law requires that the deeth certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 280 No 1 Yes Hospitei or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 💢 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€ No ٩ this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospitel or Attendil within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 07 10 9524 31. Date filed (Month, 32. Figistrar's Signature Day, Year) FEB 06 Registrar

		Please Type or Print in Black Indelible Ink. Ensure All	•	•	
		State of Maryland / Department of Health and Me	ental Hyg	giene 2007	03319
		1 - State Registrar Certificate of Death		Reg. No.	T . T
Physici		1. Decedent's Name (First, Middle, Last)  Robert C. Simmons	2. Date of Dea Month	Day Year 200	3. Time of Death 5:18 Pm
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Z	4c. County of Deat	/
LAGIIII		2211 Lowells Glen Rd. Unit K Baltimore		Baltin	nore
Funeral		Months Days Hours Min.	8. Date of Birth (Month, Day	v, Year) <u>C</u> o	hplace (State or Foreign untry) Orida
Director		453-21-1529   *LXV 2LJF   42 Yrs.   Usual Residence of Decedent	9/25/	1964 F10	orida
ryland how at		10a. State 10b. County 10c. City, Town or Location		_	10d. Inside City Limits
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If I I I I I I I I I I I I I I I I I I	Funeral Director	10e. Street and Number   10f. Zip Code   2211 Lowells Glen Rd. Unit K   21234		10g. Citizen of What Co	untry?
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after o		Armed Forces? If Yes, specify Cuban, Mexican, Puèrio F  1 ☑ Never Married 2 ☐ Married I ☐ Yes 2☑ No If Yes, Give 1 ☐ Yes 2☑No  1 ☐ Yes 2☑No Specify:	Rićan, etc.)		
ural", c	d by	3 Wildowed 4 Divorced Year or Dates:		1	White
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other vent,	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name	(First, Middle,	Maiden Surname)	
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Vidi 12 sh h and is m raum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural  2.2.1.1. The second of the s			
partitione; Ividity in the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	4	Barbara Guariglia 2211 Lowells Glen 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition 20b. Place of Disposition (Name of Disposition	ate	20c. Location - City or	
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mit. I partm portar		21 Signature of Etheral Service Licensee 22 Name and Address of Eacility		Forest F	rford Rd.
Deparmine Department Deparmine Deparmine Department Depar		Evans Funeral Chand Cremation Se	apel rvices	Parkvill	e, MD 21234
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lan: T lan: T rtificate		25. Was case referred to medical 26. Place of Death	1□ Yes	2 No 1 ☐ Yes	2□ No
nysicia nis cer direct	To Be	examiner? Hospital: Other:	,	lence 6 □Other (Spe	cify)
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after of Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or Tow	n, State)	rai noute ivumber,
ospita hours uneral ly filled		29a. Certifier  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	nd due to the	cause(s) and manner as	stated.
To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
Vith Vith Con	2	29b. Signature and title of certifier.		29d. Date signed (Monti	
h		20 Name and address of parson who completed cause of death (Item 23a) /Type Print)		2/05/0	
9		DANA FRANK 1975 FAMLS Road Stude 20	o hu	bernlo M	12/093
Sta		31. Date filed (Month, Day, Year) 32. Degistrar's Signature			
Registr		FEB 0 6 2007 Janu D. Sperk	<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3Day Feb 2007 7:25рм **Physician** Ruth M. Seabrease /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Essex 18 Terrace Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 26, 1904 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Hours 1 ☐ M 2 🛣 F 102 218-10-4032 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Essex Baltimore MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 21221 18 Terrace Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race · American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify: White þ 3€ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MAry Bach Herman J. Pfeiffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18 Terrace Road Baltimore MD 21221 Robert Seabrease /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from \$tate Parkwood Cemetery 2/6/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature of Fundral Social Licenses Connelly Funeral Home of Essex 21221 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final cronory Artery years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 Tes 2 MNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 R Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

**Examiner** or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Box 68760, P.O. 1 Division of Vital Records. After this certification within 24 hours after death. To the Funerel Director: A completely filled in by the fu

**Funeral** 

Director

ul Hygiene. other than "naturel", or items 23a or 28e-f ehow vent, the Medical Examinar must be notified at

Ith and Mental F 27 is marked of traumatic ever

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked cent injury or other traumatic evergines.

**Physician** 

/Medical

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examiner Physician/Medicai ۵ Be Completed Certification: To 156 Certifying Physician: To the best of my knowledge, death oncurred at the time, date and place, and due to the nation(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medica (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D005772 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 404-406 Easte in Blod. Baltmore MD 21221 MO 5 Teile 1.

State

Registrar

31. Date filed (Month, Day, Year) 06

32. Registrar's Signature DENL

			. 101	eartment of Health and Mental	Hygiene Reg. No.	07 03321
			Decedent's Name (First, Middle, Last)	2. Date	of Death	3. Time of Death
	Physici: /Medic		Melburn Carlisle Spaulding	Jar	<sup>th</sup> 30, 2007	7 Year 12:47 AM
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. Cou	unty of Death
			Fort Washington Hospital Center	Fort Washington		ince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 20 F XX	Months   Days   Hours   Min.   (Mon	of Birth oth, Day, Year)	Birthplace (State or Foreign Country)
	Director		236 26 2996 XX 83 Yrs.  Usual Residence of Decedent	Aug	16, 1923	B   West Virginia
	yland		10a. State 10b. County 10c. City, Town or L	ocation	-	10d. Inside City Limits
	a-fs	ctor	Maryland Prince Georges Fort W	<i>l</i> ashington		1 ☐ Yes 2 ☐ No
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen	of What Country?
	ath w	rai	749 Gleneagles Drive	20744		States
	items	Funerai	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, e		Race · American Indian, Black, White, etc.
36	irs aff	by F	1 □ Never Married 2 □ Married 1 □ M2 Yes 2 □ No 1 □ Yes, Give 1 □ Yes, Give 2 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Spe	ecify: White
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2	ed wi ygien ser th	Con		. Colonel		Airforce
and	be fill	Be	17. Father's Name (First, Middle, Last)  Raymond H. Spaulding	18. Mother's Name (First, I		name)
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. I marked other than "netural; or items 23s or 28s-f show umatic event. Ite Medical Examera must be redified at	P_		ing Address (Street and Number or Rural Route	Lloyd	um Stata Zin Codal
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event. Its Medical Examinat must be rediffed at once.		20a. Method of Disposition 20b. Place of Disp			on - City or Town, State
Ë	Page nent o nt: If		1 Burial ZATCremation 3 Hemoval from State	atory Jan 31. 2007	Clint	on, MD
a	permit. Departmimports Imports any inju		21. Signatur 1 Funeral Sevice Ligensee	22. Name and Address of Facility Lee Fun	eral Home	.Inc 6633 01d
<u> </u>	89 5 5 8	11 1	Jour A Grant moo257	Alexandria Ferry Road,	Clinton,	MD 20735
Б			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respira	tory arrest,	Approximate Interval Between Onset and Death
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8760	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d			
9	entific ling p	0	IF FEMALE:			
.O. Box	eath certific attending p for use as	Physician/M	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Date of delivery  Month Day Year
o.	that the de ed by the a detached f	ysic	1 Yes 2 No 9 Unknown 9 Unknown	_ Other (specify)		
۵.	signed by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e	. Did tobacco use co	ontribute to the cause of death?
Vital Records,	w require: been sig should be		End Stage Renal Disease		1 ☐ Yes 2 ☐ No	3 ☐ Probably 4 XX nknown
900	e law re has bee	Completed		24a	. Was an autopsy	b. Were autopsy findings available prior to completion of cause of
m —		Com		1 🗆	performed?/	death? 1 Yes 2 No
ita I	ysician: Th is certificate director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)	
of	S 5	T.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Section 25b. Time of Section 2b. Time of Section 2b. Time of Section 2b. Time of Section			
Division of	Attending Physician: sr death. ector: After this certific: by the funeral director.	tion	1 Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 28d. Des Work?  M 1 ☐ Yes 2 ☐ No	cribe how injury occ	DB11UC
ls!	Atten r deat octor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	treet, factory, office 28f. Loca	ition (Street and Nu	mber or Rural Route Number,
	afte Dir	Certification:	4 Homicide determined building, etc. (Specify)	City	or Town, State)	
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fur		29a. Certifier (Check only (Ch	th occurred at the time, date and place, and due	to the cause(s) and	manner as stated.
	the H hin 24 the F nplete	Medicai	and manner stated.			
	Viti Con	<	29b. Signature and title of certifier	29c. License number		ned (Month, Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type	D24064	1/30	2101
Ì	O		Shantha Marthy, MD, 6196 Oxon Hill I	•	7 /. /.	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	LOGICA ONOTITITIES PID 201	44	
	Registr	ar	FEB 0 6 2007 Acres 15 19	W. T.		

			For State Registrar	State of Mai	yland / D	epartm		ealth and N	Mental Hygi		7 03322	
Ī	Physici	an	Decedent's Name (First, Middle, Last)     Mary		Scott				2. Date of Death		3. Time of Death 4:45AM M	
Š	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 8602 Adios Street				city, Town, or Clinto	Location of Death		4c. County of Death Prince George's		
	Funeral Director		5. Social Security Number 6. Sex 184-24-9800							Year)   Co	hplace (State or Foreign ountry) anton, PA	
	aryland show	2	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge		10c. City, Town		nton				10d. Inside City Limits 1 ☐ Yes 2 No	
	with the M s or 28s-f be notified	Directo	Maryland   Prince Ge 10e. Street and Number 8602 Adios Stree			10f	Zip Code 20735		10	g. Citizen of What Co		
0000	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any fujury or other traumatic event, Ira Medical Examinar must be notified at once.	by Funeral Directo		12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>12</sup> Year or Dates:		_	ecedent of His specify Cubar s 27 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ame Black, Whit		
N-C1717	d within 72 horgiene. sr than "natura". It e Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation	16a.	Decedent's ( (Give kind o life. DO NO acher	Jsual Occupa f work done d T use retired)	tion uring most of work	king	6b. Kind of Business	-	
yiand	wild be file Mental Hy arked other	To Be (	17. Father's Name (First, Middle, Last) Thomas J. Collin	S					ne (First, Middle, M 1en Cuf:			
e, mar	end 2 sho eeith and I n 27 is mu		19a. Informant's Name/Relationship (Ty, Mary Ellen Scott		) 86	02 Adi	os Str	eet Clin	ton, Mar	City or Town, State, . y 1 and 2073	5	
baitimore	Pages 1 ment of H tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of cometer Cathed	ral Ce	metery	20	uary 7,	Scranton,		
Z O	Depermit Depert Import any in		21. Signature of Funding Service License	400153		6633		exandria	Ferry R		c. n, MD 20735	
¥	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line	ne death. Do n .static				or respiratory arre	st,	Approximate Interval Between Onset and Death	
	/Medical Examiner	la la	Due to (or as a consequence of):							W- 44		
,00,	nt the death certificate be executed by the ettending physicien and tached for use as the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
0x 08/	certificate iding phys se as the		IF FEMALE:	3c. If yes, outcome of	pregnancy					004 D		
	the death by the etter ached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 M No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown		3 ☐Ectop 5 ☐ Other	ic pregnancy (specify)			23d. Date of de Month	Day Year	
cords, r	requires that the death certificat een signed by the ettending phy hould be detached for use as th	ρ	256. Did tobacco use continuous to the unique typing cause given in Part.									
Ü	siclen: The law requires tha certificete hes been signed rector, page 2 should be de	Completed							24a. Was an autopsy perform	prior to death?	Itopsy findings available completion of cause of	
VIII A	iclen: certifice rector, p	Be	25. Was case referred to medical examiner?	iospital:			Otho		th (Check only one	)		
Division of	To the Hospital or Attending Physician: within 24 hours effecteath. To the Funeral Director: Affer this certific completely filled in by the funeral director.	ation: To	1 Yes 2 No F  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day)	28b. T		28c. Injury Work	4 🗆 Hursing m	ome 5 X Resider 28d. Describe how	nce 6 Other (Spe w injury occurred	cify)	
DIVIS	s effer des	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, fai (Specify)	rm, street, fa	ctory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	the Hospl nin 24 hour the Funera	edicai	(Check only 2 Medical Examilione)	sicien: To the best of ner: On the basis of e and manner state	xamination and	, death occur d/or investiga	tion, in my op	inion, death occur	rred at the time, da	te and place, and due	to the cause(s)	
)	To Too	W	29b. Signature and title of certifier	Meltz	m		D237		29	Feb 5, 20		
	1		30. Name and address of person who co				ve. Gr	eenbelt.	MD			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 6 200					,				
			LED A D S SOL	1 . July Johnson	100	4) 11-11-11						

largaret Scott	1	State of Maryland / Department of Health and Men  Certificate of Death		200	7 03323
Physicia	n/	Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of De		3. Time of Death
Medical Examir		Margaret Scott	Month January 2	Day Year 26, 2007	1328 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of 7070 McClean Blvd.  Baltimore	of Death	4c. County of Deat	ו
Europal	4		er 24Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director	],	2/8-44-824 1_M 2×F 60 Yrs. Months Days Hours	Min	Foreign	
	ľ	Usual Residence of Decedent		3 70	
ж алу		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show d at once.	흕	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	
ne Mar or 28s	Director	7070 M 9 / Jean RIVID 2123	4	1154	
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status 14. Was Decedent Ever in U.S. 15. Was Decedent Original Status 15. Was Decedent Ever in U.S. 15. Was Decedent Original Status 15. Was Decedent Ever in U.S. 15. Was Decedent Original Status 15. Was Decedent Ever in U.S. 15. Was		lo- 14. Race - Amer White, etc.	ican Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican		Writte, etc.	10-10
rs after ural",	ঠ	3 Widowed 4 Divorced If Yas, Giva Yaar 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		Specify: 16b. Kind of Business/	Industry
136 thin 72 hour te. than "nati	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)  College (1-4 or 5+)			
5-0036 Led within 7 Hygiene. I other than the Medica	d II	12th Laborer		Westing	house
	04	17.1 duties of realise (1 lively missiles)	's Name (First, Middle,	Maiden Surname)	-4.5
2121 suld be fi Mental J marked	o Be	19b. Mailing Address (Street and Num	nber or Rural Route Nu	imber, City or Town, State	e, Zip Code)
AD 2 sho h and 27 is mati		landolph Scott (SON) 12008 C. Frat	<u>+S+B</u> a	110.MD =	2/23/
ore, Nest and of Health If item		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, sernit. Pages I a pepartment of He inportant: If its injury or other training or other trai	ļ	4 Donation 5 Other Specify: SING MEADIAL FALL	1/1/0	Bato	ML
Baltim permit. Pag Department Important:	-	21 Signature of Funeral Service Licensee 22 Name and Address of Facility Company (1997)	reeye To	ineral S	eroices
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of duing, such as of	ardiac or respiratory a		Approximate Interval Between Onset and
Examiner	ı	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Death
		or condition resulting in death)  Due to (or as a consequence of):			
	ē	Sequentially list conditions, If any, leading to harmedate  Use to for as a consequence off:			
18.	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·		<del>                                     </del>
executed an and al - transit		d			
), be ex sician urial	edical	UNPENDED		22d Date of deliver	
876 tificate ng phy as the	Ž.	FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic past 12 months?	c pregnancy	23d. Date of deliver Month	y Day Year
Box 68760 e death certificate the attending physical for use as the bu	Physician/M	1  Yes 2 ✓ No 9  Unknown			
O. B. trihe de by the	P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part II.	art I. 23e. Did	tobacco use contribute to	the cause of death?
, P.O. rres that the signed by	Completed by	Schizophrenia	1Y	es 2 V No 3 Pro	bably 4 Unknown
ords, w requir	lete			opsy prior to	utopsy findings available completion of cause of
Recc The lav cate ha	E O			formed? death? 2 ✓ No 1 Y	es 2 No
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physecompletely filled in by the funeral director, page 2 should be detached for use as the b	a l	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other;	(Check only one)  Nursing Home 5	Residence 6 ✔ Othe	ar: Scene
of Vi ing Physi After this uneral dir	리	1 V Yes 2 No 28a, Date of Injury 28b. Time of Injury 28c. Injury at World		how injury occurred	, ocene
OU C ending ath. or: Af	tion	1 Natural 5 Pending (Month, Day, Year)	No		
Division of Vipital or Attending Phours after death.  Peral Director: After tiffled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, e	tc. 28f. Location or Town,	(Street and Number or R State)	ural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Directors		4 Homicide determined (Specify)  29a. Certifier 1 Certifier Physician: To the best of my knowledge, death occurred at the time, date and pl	ere and due to the on	une(s) and mapper as sta	tod
To the Hospital within 24 hours To the Funeral completely fille	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	ace, and due to the car ccurred at the time, dat	e and place, and due to the	ne cause(s)
To with	Mec	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		O.C.M.E.		January 27, 200	7
0		30. Name and a dress of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltim	IDre. MD 21201		
3	ate	Of Decistrate Signature			
Regis					
DHMH 17 Rev 1/2	001	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** ic EBRUARY 200 100 /Medical m 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTER BACTIMONE RANDALLS TOWN NONTHWEST 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) **Funeral** Min DEC. 20 1963 Months Davs Hours Country 1 ☑ M 2 ☐ F 43 219-43-5222 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Medical Exminer must be notified at 1 √Yes 2 No Director MD BALTIMORE RANDLESTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8318 LIBERTY ROAD 21244 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite mortant: If Item 27 is marked other than "natural", or Ite Application of the traumatic event, the Medical Exmilies page. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify Specify: BLACK ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CONSTRUCTION LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSE MARIE DORSEY VICTOR SCOTT ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8318 LIBERTY RD, BALTIMORE, MD 21244 ROSE MARIE DORSEY/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/07 BALTIMORE, MD MT ZION 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BALTO., MD 21217 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEPTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 31/A CONAL Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No 1∐ Yes 2 1 No 1 □ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Certification: To s after death.

I Director; After this of in by the funeral d 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completely filled in 1 is ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) · CONANAN. ne) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB 0 6

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 466 Elizabeth Scheller . Jennette 200 -ERun /Medical 4c, County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) June 17,1917 Social Security Number Age (In yrs. last birthday **Funeral** Months Days Min 1 ☐ M 2 🛛 F PA 89 217-22-4345 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show If item 27 Is marked other than "natural", or Items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8126 East Phirne Road 21061 U.S.A. death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify. þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Merit once. (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Lewis Benjamin Hoyman Edna Matilda Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8128 East Phirne Road Glen Burnie, MD 21061 Mr. Paul Scheller Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Feb. 1 XBurial 2 □ Cremation 3 □ Removal from State 2007 Glen Burnie, MD Glen Haven Mem.Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 Second Avenue SW Glen Burnie, MD 21061 101357 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, be heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RUPTUILED **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐Live birth 3 ☐ Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed certificate has been in itector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1□ Yes 2 TNO 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1<sup>⁴</sup> Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.TSn. NOW GUN BURNIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

BAZAMONE

31. Date filed (Month, Day, Year)

mosi con

32. Recentrar's Signature

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 1, **GEORGE** MARION **Physician** STOVER 2007 7:20 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGHENY AVENUE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-20-1906 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days XX M 2 F Months Hours Min 100 Yrs 215-01-7767 Director MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified once. BALTIMORE 1 ☐ Yes XX No MD. TOWSON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 ALLEGHENY AVENUE 21204 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Wes 2 □ No If Yes, Give Year or Dates: W.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: WHITE Completed by XX Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) YEARS SELF **EMPLOYED** CONTROL EXPERT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES STOVER ADELAIDE CONEY ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE M.STOVER, JR. (SON) 509 ALLEGHENY AVENUE, TOWSON, MARYLAND, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation ★ ② Other (Specify) ENTOMBM 02-07-2007 PARKVILLE, MARYLAND, 21234 PARKWOOD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD (R. G. RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongest Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CORONNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 🗶 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2**X X**No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XX Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No I Director: And in by the f after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nd manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY 2, 2007 197050 30. Name and adj ress of person who completed cause of death (Item 23a) (Type, Print) LINID 6 SHOL 6600 OS LETL 07 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2007 Registrar

Registrar

FEB 0 6 2007

			For State Registrar	State of Maryla		artment of F rtificate of			ene g. No. 2 0 0 7	03328
	Dhaminia		1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		JOHN S. STA			1		JAN	24 200:	
	Examin	er	4a. Facility Name (If not institution, give		_1		or Location of Deat	h	4c. County of Deat	
			Howard County Ge 5. Social Security Number 6. Se		al rs. last birthday)		Imbia  If Under 24 Hrs	8. Date of Birth	Howard	
	Funeral Director		218-74-5447	XM 2DE	36 Yrs.	Months Days			1970 Pue	hplace (State or Foreign untry) erto Rico
٦	land		Usuaf Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	to	Maryland Baltimo	re	Tows	חר				1 ☐ Yes 2 💢 No
	28a	ec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	h witi	<u>a</u>	1811 Indian Head	Road		212	204		U.S.	Α.
	deet	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.			specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
20	s 1 and 2 should be filed within 72 hours after deeth with the Maryland freath and Mental Hygiane. I feath and Mental Hygiane. I feath 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Madical Examinat must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No ff Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No			Specify:	
3	hour		15. Decedent's Ed		16a. Dece	dent's Usual Occur	pation	10	6b. Kind of Business/	<u>lhite</u>
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<u>8</u>	should be ind Mental I marked o	2	John Snowder	Stanley, J				Nancy	Grace	
<u>a</u>	and remmer		19a. Informant's Name/Relationship (7						City or Town, State, 2	
ב ע	1 and Health em 27 ther t		John Snowden Star  20a. Method of Disposition	ley, Jr.	1B11 D. Place of Dispo	Indian F	lead Road		, Maryland Oc. Location - City or	
2	nt of h		1 Burial 2 X Cremation 3 D	nemoval from State		osition (Name of matory or other pla		25-2007	•	
Dallillion	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other tre		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			Service C 2. Name and Addre			Towson Funeral H	Maryland
٥	Depa Impo		4-111111	gan		1050 York			aryland 21	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the de	eath. Do not ent	ter the mode of dy	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between
f	Physician		tmmediate Cause (Final disease or condition	a ADULT S						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					48h.
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_	ing ph		IF FEMALE:							
א מ	leath certific ettending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F	etal death 3	Ectopic pregnanc	у		23d. Date of del Month	very Day Year
5	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5	Other (specify) _				
ŗ.	that the phase of	y Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	Inderlying cause gr	ven in Part I,	23e. Did toba	acco use contribute to	the cause of death?
Spico	n sign	d by	SSIZURE DI	SORDER				1 □ Yes	3 2 No 3 □ Pr	obably 4 Unknown
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ב	The late ha	Completed						autopsy perform	ed? death?	compfetion of cause of
ō	artifice ctor, p	Bec	25. Was case referred to medical examiner?					ath (Check only one		
<u> </u>	hyeld his ce	၉	1 ☐ Yes 2 No		ER/Outpatier	III JUDON		T	ice 6 ⊡Other (Spe	cify)
DIVISION OF	aling P	:lol	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Wo	ryat irk? ]Yes 2. □No	28d. Describe hov	v injury occurred	
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5	s after of Dire	Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this cardicate has been signed by the completely filled in by the funeral director, page 2 should be detached	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	7/1		29c. Licen	se number	29	d. Date signed (Monti	h, Day, Year)
•			Edward Land	Went -	No		457	15	JAN 24	2007
	3		30. Name and address of person who	· ·	tem 23a) (Type,	Print) 1105	S LIT	TUE PA	TURSNI	PKWY
	)		31. Date filed (Month, Day, Year)	Chaete 1	∆∑)	cor	MMBIA	cm,	21044	,
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		rejo	7.8	Registrar  1. Decedent's Name (First, Middle, Las	t)		001	imodic	01 00	<i>-</i>	2. Date of De	Reg. No.	1111	3. Time of Death			
		Physici /Medic		Jean Y. Schla	ıch						Month	30	2007	04 SO AM			
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	li,	- Funeral Director		5. Social Security Number 6. Sec. 209–16–2744	X ☐ M 2 🛛 F	7. Age <i>(In yr</i> s. <b>81</b>		If Under 1 \		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	<sup>th</sup> / 1925		lace (State or Foreign itry) Sylvania			
				Usual Residence of Decedent													
		show	_	10a. State 10b. County			ty, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2X No			
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	9	or fter	Fur	1 Never Married 2 Married	Armed For	2 <b>X</b> No	Į.	f Yes, specify	Cuban, N	Mexican, Puerto	Rican, etc.)	3	Black, White,	etc.			
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	Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. v marked other than *natural', or items 23a or 28a-f show umaitc event, it.a Madical Exertinal rutal be notified at	To B	Albert Young						Hele	n Norri	S					
	lan	and N	•	19a. Informant's Name/Relationship (7				_			al Route Numb	-		Code)			
	€,	and lealth m 27 her tr		Claire Pacifico	(Daught		8739 Place of Dispo				rel, Ma: Date						
	Baltimore,	in ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		State	cemetery, cren	natory or othe	r place)	1			on - City or To				
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	ē	£		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betw													
4		Physician		Immediate Cause (Final disease or condition						141715			(	Onset and Death			
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1	0	Physician: The law requires that the death certificate has been signed by the attending rt this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9□ Unkno	ant at time of o	death 5	Other (speci	fy)					<b>Ju</b> , <b>Ju</b>			
1)	α.	that the	by Ph	Part II. Other significant conditions co	ntributing to de	ath but not res	sulting in the ur	nderlying caus	se given ir	n Part I.	23e. Did t	tobacco use c	ontribute to th	e cause of death?			
F)	Vital Records,	w requires been sign should be		pneum	OMIN			_			10	Yes 2□No	3 ☐ Prob	ably 4 Obnknown			
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HLAMC	Ä	The fate has	E O								auto perfo	ormed?	death?	npletion of cause of			
T	ita	ysician: 1 is certificat director, p	Be	25. Was case referred to medical examiner?		1			-	S. Place of Deat	h Check only		4.000				
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Sc		ding F h. After funera	lon:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date o (Monti	h, Day Year)	28b. Time of Injury	28c.	Injury at Work?	2 🗆 No	28d. Describe	how injury occ	curred				
	Division	he Sr.	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e, Place	of Injury - At h	ome, farm, stre			2   140	28f. Location (	Street and Nu	mber or Rura	l Route Number.			
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		the Hospital or Att.  nin 24 hours after de the Funeral Directe the filled in by the holes of the the filled in by the filled	dical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the	best of my kno	owledge, death	occurred at	the time, o	date and place,	and due to the	cause(s) and	manner as st	ated.			
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		o Twith To	-	29b. Signature and fittle of certifier	Longe			1	icense nu	0601	70	JAN	ned (Month, i	2007			
		1 A:		30 Name and hiddress of person who	ompleted cause	e of death (Ites	m 23a) /Type	1			-			/			
		IU		30. Name and address of person who de	25026	MS	2008	CATO	D	tuenus	i me	5 212	29.				
		Sta Registr		31. Date filed (Month, Day, Year)	32 A	egistrar's Signa		all )									

			For State Registrar	State of Maryland /	Department of Hea Certificate of De		ntal Hygier	211117	03330
	Physici		1. Decedent's Name (First, Middle, Last	SKIN	UER	2	. Date of Death Mopth	Day - () Yay	3. Time of Death P
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Lo	ocation of Death		4c. County of Déath	
	Funeral Director		5. Social Security Number 6. Se 216-24-0598	7. Age (In yrs. last bi		f Under 24 Hrs. 8 Hours Min.	Date of Birth	9. Birth	place (State or Foreign
	anyland	J.	Usual Residence of Decedent  10a. State 10b. County	10c City, Tow	on or Location				10d. Inside City Limits  1
	with the M s or 28a-f be notifie	Directo	10e. Street and Number 528 £. 35	W 94	10f. Zip Code	18	10g.	Citizen of What Cau	•
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at 000s.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hisparif Yes, specify Cuban, 1	(	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
D-0171	within 72 hou ene. then "natura ne Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/\$econdary (0-12)	cation 16a	Decedent's Usual Occupation (Give kind of work done during life DO NOT use retired)	on ing most of working	166	Kind of Bysiness/II	dustry
ומנות ע	should be filed with nd Mental Hygiene, i marked other ther umatic avant, the	To Be C	17. Father's Name (First, Middle, Last)	easley	18	Mother's Name (	First Millidle, Main	for Sumame)	
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allimore	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition    Burial 2   Cremation 3   F   4   Donation 5   Other (Specify)  21. Signifule of Funeral Service Licks	temoval from State	of Disposition (Name of property of other place)	2-9	-07 E	SALLINO	State U. 7. Humi
ă	permit. Departr Imports any inje		23a. Part 1. Iter the disease, or complete	BUMBY ications that caused the death. Do	not enter the mode of dying, s	Such as cardiac or r	AVE DE	Ito Mar.	Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	asullar	Colla	pse		Interval Between Onset and Death 5-10 days
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, L	res that t signed by I be detar	ρ	Part II. Other significant conditions con	ntributing to death but not resulting		n Part I.		co use contribute to	
SCOLUS,	aw requi ss been s 2 should	Completed	and stage	a e mento			1 ☐ Yes 24a. Was an		opsy findings available impletion of cause of
מושווי	n: The f ficete ha or, pege	e Com	25. Was case referred to medical				autopsy performed	? death?	
	yatcia s certi directo	To Be	examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/O	04	6. Place of Death (	/	6 □Other (Speci	60
5	ng Phy (fter thi		27. Manner of Death	28a. Date of Injury 28b.	Time of lnjury at Work?	286	d. Describe how in		<i>,</i> ,
	Attendi	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)		2 □ No 281	Location (Street	and Number or Run	al Route Number.
5	spital or sours afte narel Dir filled in		29a. Certifier + Certifying Phy	sician: To the best of my knowledg	e, death occurred at the time,	date and place, and	City or Town, St	(s) and manner as	stated.
	the Ho hin 24 h the Fu mpletely	Medicai	one) 2 Medical Exami	ner: On the basis of examination ar and manner stated.	nd/or investigation, in my opinion	on, death occurred	at the time, date a	and place, and due t	o the cause(s)
			29b. Signature and title of certifier	Heillenn	200	18860	1	Date signed (Month,	
-	1		33. Name and address of person who co			D 2121	8 5.	1 to 55.5	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 6 200	32 Gistrar's Signature	hind				

	1	For State Registrar	State	of Maryla		artment of rtificate of		d Mental I	Hygien Reg. N	21111	03331	
Physiciar /Medica	١	1. Decedent's Name (First, Middle, ERN.			SC	HOENBER	3	2. Date o Month FEB	f Death RUARY	<sup>≋y</sup> 1, 2007	3. Time of Death 7:10 Ам	
Examine	44	ta. Facility Name (If not institution, 725 MT. WILSO)	_			4b. City, Town,		SVILLE	40	c. County of Deat	LTIMORE	
Funeral Director		212-18-3182	3. Sex 1 □ M 2 ▼ F	7. Age (In yr.	s. last birthday)  6 Yrs.	If Under 1 Yea Months Days			6/192	9. Birt	hplace (State or Foreign untry) GERMANY	
faryland show ed at		Usual Residence of Decedent  10a. State 10b. County  MD BAL	TIMORE	10c. 0	City, Town or Lo	cation (ESVILLE					10d. Inside Cify Limits 1 ∐Yes 2 X No	
with the Mar a or 28a-f si be notified		10e. Street and Number 725 MT. WILSO		4700	1 11	10f. Zip Code	21208	0	10g. C	itizen of What Co	untry?	
Ind 21215-0036  be filed within 72 hours after death with the Maryland tial Hygiene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	3	11. Marital Status  1 X Never Married 2 Marrie	12. Was De	cedent Ever in Forces? 2 2 No Give		Was Decedent of feet of the f	Hispanic Origin ban, Mexican, P		r No-	14. Race - Ame Black, White Specify:	rican Indian,	
2 2 3	leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent' (Specify only highest	Year or Education	Dates:	16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e during most of	working	16b. l	Kind of Business/		
Maryland 21215- d 2 should be filed within 72 th and Mental Hygiene. t7 Is marked other than "nat traumatic event, the Medics	najaidiiina s	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L		(1-4or 5+)	BUY			Name (First, Mic			S APPAREL	
Taryland 2 2 should be filed and Mental Hygi Is marked other aumatic event, it	2	HERMAN  19a. Informant's Name/Relationsh		S(	CHOENBER		MATI	HILDE		or Town, State, 2	ROTEN	
	-	CAROLYN COOPE		FRIEND	21 CO	DBBLE CO	URT - BA		, MD			
E Fa Fa Fa		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	ecity)	a State	cemetery, crer HEVRA Al	HAVAS CH	ESED 02,		7 R	ANDALLS	TOWN, MD	
Balt permit. Departr Importa any inju	1	Michael	Drug	ser			ISTERSTO	OWN ROAD	- PI	N & BROS KESVILLE	, MD 21208	
Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one coase on	i each line.	Carce		ying, such as car	rdiac or respirato	ry arrest,		Approximate Interval Between Onset and Death 3 ~~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
/Medical Examiner		Sequentially list conditions	b. ———	o (or as a 🕹 nse								
executed ial-transit	Yallille	if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last	С	o (or as a conse								
cate be executed physician and the burial-transit	2		d									
BOX 6 ath certifi	ruysiciaii/ivie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 □Live	outcome pf preg e birth 2  Fe gnant at time of known	tal death 3	]Ectopic pregnan ] Other (specify)	су		_	23d. Date of del Month	ivery Day Year	
wrequires that the debeen signed by the a	2	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause ç	jiven in Part I.			use contribute to	the cause of death?	
	completed							—   a	Vas an autopsy performed? es 2 N	death?	topsy findings available completion of cause of	
Or Vital F Physician: Th this certificate ral director, pag	ם ס	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	]Inpatient 2	☐ ER/Outpatien	t 3□DOA	thor:	Death (Check of		6 □Other (Spe	cify)	
Tarter Ing		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigi 3 ☐ Suicide 6 ☐ Could no	ation (Mo	te of Injury onth, Day Year)	28b. Time of Injury	M 1[	☐Yes 2☐No			ury occurred	und Route Alumbas	
DIVISIO pital or Attend urs after death eral Director: /		4 Homicide determin				eet, factory, office		City or	Tòwn, Stai	te)	ıral Route Number,	
To the Hospital of within 24 hours af To the Funeral completely filled it	Medica	(Check only one)  29b. Signature and title of certifier	xaminer: On the	basis of exami anner stated.	nation and/or in	vestigation, in my	opinion, death	occurred at the ti	ime, date ar	s) and manner as nd place, and due ate signed (Mont	to the cause(s)	
5358		> Jun	MO				38675	-	Fel		2007	
10		30. Name and address of person v  1 0 E	ru vam	301	ST PAUL	CL	#605	BALTIA	MORE	MO	4202	
State Registra	1	31. Date filed (Month, Day, Year) FEB 0 6 2007  Registrar's Signature										

			For State Registrar	State of Maryland		nent of Healtlicate of Deal		giene 0	07 03332
			Decedent's Name (First, Middle, Las	0 1			2. Date of D	eath	3. Time of Death
	Physici /Medic		Cecelia	ottzmai	$\land$		- Month Febru	0 ry 4 2	Year 945 A M
	Examin		4a. Facility Name (If not institution, give	street and number)	45	City, Town, or Location		4c. County	of peath TIMOVE
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs, la	Mo	Under 1 Year If Under 1 Year I	der 24 Hrs. 8. Date of Bi rs Min. (Month, D Januar	rth a <i>y, Year)</i> y 8, 1934	Birthplace (State or Foreign Country)     New Jersey
	PC .		Usual Residence of Decedent	100 Cit.	Town or Location				104 Inside City City City
	ehov	5	10a. State 10b. County	Too. City,	TOWN OF LOCATIO				10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	Maryland H  10e. Street and Number	oward	1	Ellicot Of. Zip Code	t City	10g. Citizen of	
	with a or	급			'		21042	rog. Onizon or	U.S.A.
	ne 23	Funeral	10006 Fox Den Rd.	12. Was Decedent Ever in U.S	. 13. Was		Origin? (Specify Yes or Nican, Puerto Rican, etc.)	o- 14. Ra	ce - American Indian,
21215-0036	be filed within 72 hours after deeth with the Maryland that hygiene. Adouter then "neturel", or terme 23a or 28e-f ehow event, the Medical Examinant has untified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 ANo If Yes, Give Year or Dates:		s, specify Cuban, Mex Yes 2 <b>)</b> No <i>Spe</i> c		Specil	ck, White, etc. <sup>(y:</sup> White
20	72 ho	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent	s Usual Occupation of work done during r	nost of working	16b. Kind of B	dusiness/Industry
2	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO l	VOT use retired)		Ente	erprise Development
	filed w Hygier other th	ပိ	47 Fathada Nama /First Middle / math	2		Administrative	e Assistant other's Name <i>(First, Middl</i> e	Mainte - Cumpa	Corp.
Maryland	2 should be filed with and Mental Hygiene ie marked other the eumatic event, the	Be	17. Father's Name (First, Middle, Last)			18. M			
2	should be fand Mental I	ဥ	August 19a. Informant's Name/Relationship (7	us O'Hare	19b. Mailing A	ddress (Street and Nu	mber or Rural Route Numi	ecilia Roser	
S	무료없는		. 9 4				Ellicott City, Maryla		
ē,	ges 1 and 2 t of Health if item 27 i		Ms. Patricia J. Bakuni 20a. Method of Disposition	20b. Pla	ce of Dispositio		Date		- City or Town, State
Ë	Part		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	•	mation Service	02/08/2007	Sy	kesville, Maryland
Baltimore,	permit. Page Department importent: eny injury once.		21. Signature of Funeral Service Licen			me and Address of Fa	acility		
			23a, Part1, Enter the disease, or comp	dications that caused the death.	Do not enter th	3871 Old C	eral Home, P.A. Columbia Pike Ellic	ott City, ME	Approximate
, III	Dharatatan		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of tmmediate Cause (Final	one cause on each line.			,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseque	ance of):	gncer			months
П	Examiner			<b>L</b>					
	D ==	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
	acute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c					
8760,	ate be executed hysicien and the burial-transit	E	Tooding in doubly Eucl	Due to (or as a conseque	ance or):				
387	physicate physicate	dicai		d					14 100 17 100 100 100 100 100 100 100 100
Box 6	The law requires that the death certificate be executed site has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan				23d. Da	ate of delivery
	death e ette d for	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetet of 4 Pregnant at time of dea		opic pregnancy ner (specify)		Mo	onth Day Year
P.0	that the di ed by the detached	hys	9 🗆 Unknown	9□Unknown					
	es tha igned be dei	by F	Part II. Other significant conditions of	ontributing to death but not resul	ting in the under	lying cause given in Pa		_	tribute to the cause of death?
ord	w requir been si should	ted					1 🗆	Yes 2□No	3 ☐ Probably 4 ☐ Unknown
of Vital Records,	e law i has be	Completed					24a. Wa auto	posv	Were autopsy findings available prior to completion of cause of
E	: The cete !	S					per 1 ☐ Yes	ormed? 2 ☑ No	death?
Vit	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		Othor	lace of Death Check only		Subacute
ō	Phys r this ral dii	<u>۲</u>	1 Yes 2 No  27. Manner of Death	1   Inpatient 2   E	R/Outpatient 3 28b. Time of	1 DOA   4L	Nursing Home 5 Res	idence 6 00th	ner (Specify) UNIT
Division	ding h. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Intury	28c. Injury at Work? U 1 ☐ Yes 2		non injury coods	
IS	Attendii death. octor: A by the fu	flca	3 Suicide 6 Could not be	28e. Place of tnjury - At hon	ne, farm, street,		28f. Location	(Street and Numi	ber or Rural Route Number,
<u>S</u>	al or A s efter if Direct id in by	Certification:	4  Homicide	building, etc. (Specify)			City or To	own, State)	
	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funarel Director: After this certificete his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know liner: On the basis of examination and manner stated.	rledge, death occorn and/or invest	curred at the time, date gation, in my opinion,	and place, and due to the death occurred at the time	cause(s) and m	anner as stated. and due to the cause(s)
	To th Within To th	Me	29b. Signature and titte of certifier	1.11	1 1	29c. License numb	er	29d. Date signe	ed (Month, Day, Year)
			(prestine t	ajum Hospi	1ta 157	62913	2	Februe	vy 4 2007
	13		30, Name and address of person who christine kaju	completed cause of death (Item)	23a) (Type, Prin	"oad Ra	ndallstor	on Ma	aryland
	Sta	ate	31. Date fited (Month, Day, Year)	32. Registrar's Signatu					
	Regist	rar	FEB 0 6	2007	K So	sele!			
DH	MH 17 Rev 1/2	2001		APP					

ORIGINAL

	1- State State Registrar  Certificate of Death  Reg. No. 2007 03333												
Dhysisian		1. Decedent's Name (First, Middle, Las	:t)					2. Date of De		Year	3. Time of Deat		
Physiciar /Medica	١.	CARMELLA				TEDESCO		JANUAR		, 2007	11:05 P.	М.	
Examine	r	4a. Facility Name (If not institution, give FOREST HILL HEALT	,	CENT	ER	4b. City, Town, or FORES	Location of Death  ST HILL		4c.	County of Deat HARI			
Funeral		5. Social Security Number 6. Se	ex 7. Age	e (In yrs. la	st birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth av. Year)	9. Birti	nplace (State or Foreuntry)	reign	
Director	-	095-16-4518 Usual Residence of Decedent	□M 2XF 8	35	Yrs.	Monais Bayo	TIOGIO IVIII.	Dec. 2	Ź <b>,</b> 19	21 1	New York		
/land ow at	- H	10a. State 10b. County		10c. City,	Town or Le	ocation					10d. Inside City Lin	nits	
a-f sh	20	Maryland Harf	ord			Bel Ai	ir				1 □ Yes 2 📉	]No	
or 28	Cire	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?				
sath was 23a must	Funeral Director	719 Tobacco Run	Drive 12. Was Decedent E	ever in U.S.	13		21015	necify Yes or No	U. S. A.  (v Yes or No- 14. Race - American Indian,				
2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		Rican, etc.)		Black, White			
ural",	g D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10- D				4.0h 16		Mite		
in 72 ł	Be Completed	15. Decedent's Ed (Specify only highest gra	de completed)	,	(Give life.	edent's Usual Occupa e kind of work done o DO NOT use retired,	ation Juring most of work )	king	100. KII	6b. Kind of Business/Industry			
d with giene. er than	Ę	Elementary/Secondary (0-12)	College (1-4or 5- 1 Year	+)		Supervis	sor		Accounts Payable				
be file tal Hy d othe	Pe C	17. Father's Name (First, Middle, Last)					18. Mother's Nam	,		· · · · · ·			
d Men narke natic	2	Nicholas Teska  19a. Informant's Name/Relationship (7)	Tuno Print)		10b Mail	ing Address (Street s		abeth Ca			Zin Codo)		
and 2 sh ealth and <b>n 27</b> is r		Albert P. Tedesco		,						ity or Town, State, Zip Code) , Md. 21015			
of Heal	-	20a. Method of Disposition				osition (Name of ematory or other place		Date		Location - City or Town, State			
Pages ment of the ant: If ite		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specify</i>	y)		yview	Crematory	02/04			ltimore, Maryland neral Home of Bel Air			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen		ne of Bel Id. 21014	Air								
	$\dashv$	23a. Part1. Enter the disease, or comp shock, or heart failure. List only		Approximate Interval Between	1								
Physician		Immediate Cause (Final disease or condition		sep	nio						Onset and Death	n	
/Medical Examiner		resulting in death)	Due to (or as a										
п —	Je.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	a conseque	ence of):								
nd //	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C										
		resulting in death) East	Due to (or as a	a conseque	ence ot):								
ficate p physics the	ledical	`	d										
		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			□Ectopic pregnancy			2	23d. Date of del			
Attending Physician: The law requires that the death cen releath. ector: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	Physician/II	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify)				Month	Day Year		
that the the the the detac	Z.	Part II. Other significant conditions of	ontributing to death bu	ut not result	ting in the	underlying cause give	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death	?	
quires an sigr uld be	ed by	CVA						10	Yes 2[	□No 3□Pr	obably 4 Unkno	own	
e law re has bee	Completed	aturel Jobs	Male					24a. Was	psy	prior to	topsy findings availa	able of	
: The cate h								perf 1□ Yes	ormed? 2 ☐ No	death? 1 ☐ Yes	<b>≥</b> □ No		
sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:		D/Outpotic	ont all DOA Othe	26. Place of Dea				***		
g Physer this eral di										y occurred	city)		
endin eath. or: Aft he fun	2 Accident investigation M 1 Yes 2 No												
or Att after de Direct in by		4 ☐ Homicide determined	28e. Place of inju- building, etc	ury - At hon c. <i>(Specify)</i>	ne, farm, s	treet, factory, office		28f. Location City or To	(Street an own, State	d Number or Ri )	ıral Route Number,		
	Medical C		nysician: To the best of miner: On the basis of and manner sta	f examinati									
Fo the within 2 Fo the comple	Mec	29b. Signature and title of certifier	and manner sta	alou.		29c. License	number		29d. Dat	e signed (Mont	h, Day, Year)		
./		David 5	Dia			2) 3	2279		Jeb	rusan	3,200	7	
5		30. Name and address of person who					71 ATD 3			)			
Stat	e	DR. DAVID DUNN - 31. Date filed (Month, Day, Year)	615 W. M. 32 Registra		ire		EL_AIR, M	ID. 210	114				
Registra	TTD A C ODOT												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:50A M **Physician** Weston Charles Tucker Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death Examiner Square Daltir -ranklin If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) (In yrs. last birthday Date of Birth **Funeral** (Month, Day, Year) 4/17/1926 West Virginia 80 Yrs 217-20-7757 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at an once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 usa 9945 Hilltop Dr. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Conrail Policeman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Dunivant Willie C. Tucker ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Middle River, MD 21220 3835 Bay Dr. Bryce L. Tucker/ son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral

Chapel - Bel Air FEBRUARY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Forest Hill, MD 8800 HarfordRd. Parkville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel And Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No The faw certificate has autopsy perform 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be examiner? 1 ∐ Yes 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manyrer of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours at er death.

To the Funeral Director A
completely filled in by the ft 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 50000C of death (Item 23a) (Type, Print) 30 Name and address of person who completed

Registrar

State

31. Date filed (Month, Day,

Franklin

9000

32. Registrar's Signature

	1 - For State Registrar	State of Mary		rtment of H			giene Reg. No.	07	03335
Physician		H.	Turner			2. Date of De Month	Day	Year	3. Time of Death
/Medical			rurier	4b. City, Town, or	r Location of Deat	b Januar		2007 inty of Death	((.13 pq,
	Baltimore Washing		Center	Glen Bu	ırnie		An	ne Aru	nde1
Funeral	5. Social Security Number 6. S 220–24–2050	Gex 7. Age (In IX M 2 □ F	yrs. last birthday).	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th iy, Year)	9. Birtho	place (State or Foreign
Director	Usual Residence of Decedent		70 113.			March	15,192	8	MD
thow	10a. State 10b. County		c. City, Town or Lo	cation				1	0d. Inside City Limits
with the Marylar s or 28a-1 show be notified at	MD Anne Aru	nde1	Glen B						1 ☐ Yes 2 ☑ No
death with the Maryland ms 23a or 28a-f show fritual te notified at	10e. Street and Number			10f. Zip Code 21060				of What Cour	ntry?
ifter death v	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. y	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (5	Specify Yes or No	U.S.	Race - Americ	
M & # # # M		1 XYes 2 No		Yes, specify Cuba		to Rican, etc.)		Black, White, ecify: Whi	
21215-0036 ad within 72 hours after gigner. In Medical Examination Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Programme Compilered by European Compilered by	3 Widowed 4 Divorced	Year or Dates:							
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Baltimore, Maryland bernit. Pages 1 and 2 should be file appending to the library is marked oth my fillury or other traumatic event and its and the library or other traumatic event and its a	4 □ Donation 5 □ Other (Special	fy) G	arrison 1	Forest Ce	em.	2007		gs Mil	
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the Hospitei hin 24 hours of the Funeral mpletely filled	(Check only 2   Medical Example one)	hysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	estigation, in my o	pinion, death occ	e, and due to the urred at the time,	date and plac	ce, and due to	the cause(s)
To the common co	29b. Signature and title of certifier			29c. License	e number		29d. Date sig	ned (Month.	Day, Year)
	Mame and address of person who	completed cause of death	(Item 22a) /Time (	1) 4	39-11		Jamo	ery 3	3) 2007
4	Charles and address of person who	1 3DI H	(1900) (1900, 1	live.	Eden &	urn è	. MA	0. 2	inht.
State Registrar		32. Registrar's 9	Signatu/e	rach o			,,,,,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician CLANIS 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOY ITAL RANDALLS NORTHWEST BALTIMORZE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 WV 6. Sex 8. Date of Birth (Month, Day, Year, 5. Social Security Number . Age (In vrs. last birthday **Funeral** Months Days 1 X M 2 □ F 235-56-1321 69 24 1938 Director Jan Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Md Carroll Eldersburg 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 7038 MacBeth Way Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: tems ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) maintenance engineer Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clavis Andrew Thomas Sr. Sylvia Rae Youngs ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7038 MacBeth Way, Eldersburg, MD 21784 Connie Thomas (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 2-2-07 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dauge Haught Sterbert P.O. Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOVAJCULAR DISEALE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be execute that initiated events resulting in death) Last **S**B Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical asn 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□ Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 **V**No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes 2 27. Marvier of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007

State Registrar

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31. Date filed (Month, Day, Year)
FEB 0 6 201

20 TUKIN

MILLAGEL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 1735 PM Februar 1 aylor Villiam 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kaltmore The Johns opkins tospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 1933 Social Security Number (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F Days Hours Months Maryland 219-30-1875 73 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in 907 Fitzpatrick Drive 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Public School System Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Elmer Forest Taylor Edna Dora Dolan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maude Taylor/ Wife 907 Fitzpatrick Dr., Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If ite any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial 2-7-07 Fallston, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Mana and Address of Facility Home, P.A. Cussell len 50 West Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Hyporolemic disease or condition resulting in death) MINIUTES /Medical Due to (or as a consequence of): Examiner FOU SCHEMIC Sequentially list conditions, leave. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed HETERY and burial-trai Due to (or as a consequence of): Box 68760, physician Physician/Medical the ass attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>\$</u> 1 🕱 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 : performed After this certificate funeral director, pag 1∐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident To the Hospital or Atterding within 24 hours after death.

To the Funeral Director Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6209 TEBELARY OR, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. STYFET Dathmore (200 GODI 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 6 State Registrar

		1	For State Registrar	State of Maryla		artment of F		R	eg. No. Z	07 03338
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3	the N 28a-f notifi	Director	Maryland Baltimo	) e	υαιτι	10f. Zip Code		1	l0g. Citizen of Wha	at Country?
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\	1 and 2 Health a em 27 is		Ruthanne Topping	y Wife	7817	<b>Overbrook</b>				and 21204
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Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.			gan	ner	1050 Yo	ork Road			al Home, Inc. nd 21204
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of exar and manner stated.	knowledge, de nination and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
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	30			o completed cause of death (	Item 23a) (Type	e, Print)	140 141	Dal -las	P Are BALL	mme MM 21715
			Eileen Zingmar 31. Date filed (Month, Day, Year)	7 DO Sinai Hos	11701 6+ 1	Baltiriore	401 West	beivede!	care buil	more juin ZILIS
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4			1 - For Registrar Amend #14 Per FH G865 3/05/CTerd	ficate of Death	2. Date of De	Reg. No U	3. Time of Death							
	Physicia /Medic		Daniel Daisuke Takeoka		FEBRUA	ARŸ <sup>Day</sup> ≥,E	2.20FМ м							
	Examin		4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Dea		4c. County	of Death Saltimore							
	Funeral Director		542-14-2306 1XIM 2DF 84 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		in 1922	9. Birthplace (State or Foreign Country) Uregon							
	Aaryland f show ed at	or	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 □Yes 2 🏋 No							
	or 28a-	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of V	•							
	eath w	Funeral	110 Westbury Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	as Decedent of Hispanic Origin? (	Specify Yes or No	USA 14. Race - American Indian,								
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Division or Vital Records,	yslclan: The law requir is certificate has been si director, page 2 should	Completed			24a. Was autop perfo 1∐ Yes	rmed?	Were autopsy findings available prior to completion of cause of leath?  ☐ Yes 2 ☑ No							
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or	Phys this ral dir	<u>유</u>	1 Yes 2 No Prospiration 2 ER/Outpatient 2 ER/Outpatient 27. Magner of Death 28a. Date of Injury 28b. Time of	3 DOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Resid	dence 6 Othe								
ion	ending ath. or: After he funer	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	now injury occurr	<del></del>									
O X	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)		City or Tou	vn, State)	er or Rural Route Number,							
	le Hospl 124 hour le Funer letely fill	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the best of my knowledge, de	occurred at the time, date and place estigation, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)							
	To th Withir To th comp	Me	29b. Signature and title of certifier  Research MA	29c. License number			(Month, Day, Year)							
	1011		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr			21012								
	10 ·		RONOLD SCHECTHER M D. 7601 OSLEJ	D DEIUE TOWS	ON, MAR	RYLAND	21204							
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature FEB 0 6 2007	WKL)										
DH	MH 17 Rev 1/2	2001												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Nancy Curtin Terrill February 5:16 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4645 Old Dragon Path Ellicott City Howard 8. Date of Birth (Month, Day, Year)
April 16,1948 Washington, D.C 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 S F 214-52-4677 58 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4645 Old Dragon Path 21042 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Elementary Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Curtin Margaret Steele 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Terrill (Husband) 4645 Old Dragon Path Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 2-7-2007 Catonsville, Maryland 4 Donation 5 ☐ Other (Specify) Witzke Funeral Homes, Inc. 21. Signature of Euneral Service Vicensee 5555 Twin KNolls Road Columbia, MD 21045 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1, Enter the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) slet Physician Cell tunov /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Month 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 3 ☐ No 24a. Was an page 2 s autopsy performed? Yes 220No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🔲 Inpatient ၉ 1 ☐ Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After Injury 1 Natural 5 Pending investigation within 24 hours after wear...

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)4113 2007

Registrar

State

11065 Little Patuxent Parkway Columbia, Maryland 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. C. Knight M.D.

06

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **Physician** 2.00 IAJ CHMAN ANKIEL 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 DOL AND 8. Date of Birth **Funeral** Months Days Hours 0570571927 **POLAND** 79 220-50-2561 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No **Funeral Director** MD BALTIMORE BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 21208 11 SLADE AVENUE #115 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after all Hygiene. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No WHITE Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TAILOR GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Menta ANGLISTER CHAIM TAJCHMAN SARAH MOSHE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SLADE AVENUE #115 - BALTIMORE, MD 21208 f Health item 27 i SOPHIE TAJCHMAN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 X Burial 2 □ Cremation 3 □ Removal from State FINKSBURG, MD BETH JACOB CEMETERY 102/04/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUER disease or condition resulting in death) METASTATIO /Medical Due to (or as a consequence of): **Examiner** b. HYFLAMMA TORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): of a rustry physician and s the burial-trans Due to (or as a consequence f): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒ No 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only

The law requires that the death certificate be executed P.0. Division or Vital Records, al or Attending Patter death. within 24 hours after deam.

To the Funeral Director: Aft Hospital

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

filed (Month, Day, Year)

FEB 0 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

JUGINDER RAMORU

41410

29d. Date signed (Month, Day, Year)

0

February

			1 - For State Registrar	State of N	Marylan	•		nt of H				giene Reg. No.	00	7	03342	
	Physici	an	Decedent's Name (First, Middle, La	_	_	1		1111	RICH	,	2. Date of De Month	Day	Ye	ar	3. Time of Death	
	/Medic	al	MICHAEL  4a. Facility Name (If not institution, given		AC	K	4b. City	. Town, or			JANUAR		County of I	07 Death		
	Examin	er	HARBOR HOSPITA		,			ALTIN								
	Funeral Director		5. Social Security Number 6. 5			last birthday) 48 Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 1/20/	y, Year)		Count	ace (State or Foreign ry) NGTON, DC	
	pue *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits	
	Maryli f eho	to	MD PRINCE G	EORGE'S	HAR	DWOOD									1 XYes 2 ☐ No	
	r 28a	Director	10e. Street and Number				10f. Z	p Code				10g. Citiz	zen of Wha	I Coun	ry?	
	23a o		1502 H FLOUNDER	LANE				776					S.A.			
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ideal Exartinar must be inclifted at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 X Divorced	12. Was Deceder Armed Force 1 Tyes 2X If Yes, Give Year or Date:	s? <b>X</b> No		Was Dece If Yes, spe 1 🗌 Yes		spanic Or n, Mexica Specify		ecify Yes or No Rican, etc.)	1	4. Race - Black, Specify:	White, e	itc.	
2-0	72 ho	eted	15. Decedent's E (Specify only highest gr			16a. Dece	kind of w	ork done d	during mos	st of work	ing	16b. Kir	nd of Busin	ness/Ind	ustry	
121	within iene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4c	r 5+)		DO NOT	ise retired	)							
d 2	Hygi ther int,		12 17. Father's Name (First, Middle, Las	7)		WE.	LDEK		18. Moth	er's Nam	e (First, Middle		RIVAT: Sumame)			
lan		To Be	MILLARD	ULRICH					M	ARY						
Maryland	S 8 8 10		19a. Informant's Name/Relationship				•	Address (Street and Number or Rural Route Number, City or Tourn VINTRY CLUB CT. LANDOVER, MD							Code)	
Baltimore,	Pages 1 and 2 nent of Health snt: if item 27 i ury or other tru		20a. Method of Disposition  1 Burial 2 XCremation 3 ( 4 Donation 5 Other (Spec		te	Place of Disponentery, cres	matory or	other plac			Date 2007	BRENTWOOD, MD				
alti.	교원단금 .		21. Signature of Funeral Service Lice		FI	22	2. Name a	nd Addres	s of Facil	ity FT	LINCO	LN FU	MERA	L HO	ME	
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* A.S.	Physician		23a. Part1. Enter the disease, or cor shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	n line.						or respiratory a				Approximate Interval Between Onset and Death	
	/Medical Examiner	-er	Sequentially list conditions, if any, leading to immediate	ESOPH	p (or as a consequence of):  PHAGEAL VARICES BLEED  o (or as a consequence of):										24 HOURS	1
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,092	eath certificate be executed attending physician and for use as the burial-transit	cal Exa	resulting in death) Last	Due to (or	as a consec					S				4	a Hours	
89	ifficate g phy as the			0.												
Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 Fetal	al death 3[	⊒Ectopic ⊒ Other (s	oregnancy specify)				2	23d. Date o Month		ry Day Year	
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Re	The la	mo									auto perf 1 ☐ Yes	psy ormed? 2 No	dea	ith?	npletion of cause of	
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of V	ding Physician; The lav n. Alter this certificate has funeral director, page 2	P	1 ☐ Yes 2 ☑ No	Hospital: 1 Mnp		ER/Outpatie			4 🗆 1	lursing H	ome 5 Res				')	
N C	fing P	ion:	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of 1 (Month,	njury Day Year)	28b. Time o Injury	ot M	28c. Injur Wor	yat k? Yes 2.[	7No	28d. Describe	now injur	y occurred			
Division	or Attending ifter death. Director: After in y the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At h , etc. <i>(Speci</i>							(Street an wn, State		or Rura	l Route Number,	
<u> </u>	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in y the	Medical Ce	29a. Certifier 1 Certifying (Check only one)	hyuician: To the beaminer: On the basi	s of examin	cwledge deal ation and/or in	th occurra	d at the tr on, in my o	ne, date a pinion, de	ind place, eath occur	and due to the rred at the time	causa(s) , date and	and mann I place, and	nar ns si d due to	the cause(s)	
	o the o the omple	Mec	29b. Signature and title of certifier	and mainten	,,,,,,,,,		2	9c. Licens	e number		i	29d. Dat	e signed (	Month,	Day, Year)	
	⊢ 3 ⊢ ŏ		Mamusa - ME	DICAL DO	CTOR,			RES	000			JANU	ARY	30	2007.	
	1		30. Name and address of person wh	completed cause	of death (Ite	m 23a) (Type	Print)	-		MITIN	INDE HAD				BALTINO	PE
85	St.	ate	31. Date filed (Month, Day, Year)		istrar's Sign				3. (31		CAL III	- A more	-21.4	٠.;	W -7 11101	-4-
	Regist		FFR 0 6 2	nn7	16 de	A Ja	MIL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2001 eb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City Town, or Location of Death Examiner torc 6. **Sex**. 1 M M 2 □ F If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign I Security Number **Funeral** Months Days Hours 219-34-212 Usual Residence of Decedent Yrs. Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes Specify: Maryland 21215-0036 þ Whit 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Valle 3000 Se Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 20c. Location - City or Town, State 3 ☐Removal from State Higher ew Menr. Garden's 7/07 Fallston 10:1 Italiston, MD Forest Hill, MD 21050. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses polx Cremation Services-Belfir Evans Funeral Cha or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Fina disease or condition resulting in death) DISSOCIATION MAGNETIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Records, 1 ☐ Yes 2 No 3 Probably 4 Hunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 24 No 24a. Was an autopsy Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 □ DOA Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Tes 2 🗌 No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 200 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) ,7505 OSLERDRING, SUITE 206, TOWSON, MD 21204 DANUSHA, SIRITHARA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

FEB 06

2007

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 0518 VENABLE ALLAS FEB 2 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BAL SAMARITAN HOSPITAL TIMORE 5. Social Security Number 7. Age (In yrs. last birthday) ear If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 1XM 2□F Months Days Hours Min. 341-26-9663 73 Mar. 26, 1933 Illinois Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3325 Willoughby Beach Rd. 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Marned Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 District Sales Manager Auto Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

Hilltop Service Corp

INFARCTION

rai', or items 23a or 28a-f ebov Examinar must be notified at the permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any injury or other traumatic event, the Medical Examinar must be as anse. 21215-0036 Baltimore, Maryland

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

2

**Funeral** 

Director

**Physician** /Medical

**Examiner** 

physician and s the burial-translt as use ξ signed by should be this certificate has page 2 To the Hospital or Attending Physician: After death Director:

Be

P

Certification:

Medicai

within 24 hours after dea To the Funeral Director completely filled in by th

State Registrar

Examiner Physician/Medical 2 Completed

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

20a. Method of Disposition

21. Signature of Funer

Shellie Everett Venable

2 ☑ Cremation 3 ☐ Removal from State on 5 ☐ 9 Ther (Specify)

19a. Informant's Name/Relationship (Type, Print)

Eleanor Venable/Wife

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Dipknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown

in the past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of death 9 Unknown	5 ☐ Other (specify)
Part II. Other significant conditions co	entributing to death but not resulting in	the underlying cause g

MYOCARDIAL

Due to (or as a consequence of):

BRONCHIOLITI

Due to (or as a consequence of)

IFF USE Due to (or as a consequence of):

ALVEOUR 23d. Date of delivery Month Day Year

Martha Corine Gidcumb

<sup>22. Name and Address of Facility</sup>
McComas Funeral Home, P. A.
1317 Cokesbury Rd., Abingdon, Maryland 21009

OBLITERANS DACANIZING PURIMONIA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3325 Willoghby Beach Rd., Edgewood, MD 21040

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State

2-5-07

	4∐Pregnant at time of c 9□ Unknown	death 5 ☐ Other (s)	pecify)		22,
	ributing to death but not res	sulting in the underlying of	-	1 □ Yes 2 🗹	
			26 Place of De	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes  No
Н	ospital: 1 Mnpatient 2	ER/Outpatient 3 D0	Other	dome 5 Residence 6 [	Other (Specify)
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
9	28e. Place of Injury - At h building, etc. (Specia		y, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,

BLUD BALTIMORE MA

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated.		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
11.	DSC - 000	5 - 2

FEB 0 6 2007

5 Pending

investigation

6 Could not be determined

29c. License number RES-ODO

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Towson, Maryland

Approximate Interval Between Onset and Death

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVEN

5601 HAKIM LOCH 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			State of Ma	aryland / Depa <i>Cei</i>	artment of H			ene 2007	03345		
	Physicia		Decedent's Name (First, Middle, Last)     Thomas Joseph Wall				2. Date of Death Month Feb. (	Day Year 05, 2007	3. Time of Death 8:40 A. M		
7	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	TCD.	4c. County of Death			
			8003 Gough Street			timore		Baltimore County			
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1	9 (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) OCt • 08,	(ear) 9. Birt Co	hplace (State or Foreign unity) timore, MD.		
			Usual Residence of Decedent				1002.0072	Dai			
	arylan show		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No		
	the Mi	Director	Maryland Baltimore County  10e. Street and Number	Baltimo	10f. Zip Code		100	0g. Citizen of What Country?			
	as or				,	21224		United States			
	death	Funeral	8003 Gough Street  11. Marital Status  12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba			14. Race - Ame Black, Whit	ncan Indian,		
92	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow colcel Examinar mast be notified at	y Fu	1 ☐ Never Married 2½ Married 1½ Yes 2 ☐ N	₀ Korean	1 ☐ Yes 2X No		,	Specify: Wh			
ë	hour tural	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a Dece	dent's Usual Occupa	ation	10	Sb. Kind of Business/	Industry		
_	- 1	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Give	kind of work done of DO NOT use retired	turing most of work )	ring				
2	ed wit	Con	10 n/a		heet Meta			Sheet Me	tal Work		
Maryland 21215-0036	I be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Last)  John Wall			Irene Co	e (First, Middle, Ma uahlin	aiden Sumame)			
Ž	should nd Me mark imatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a			City or Town, State, 2	Zip Code)		
Ž.	alth al		Shirley Joan(nee Belt)Wall(	wife) 8003	Gough St	reet B	altimore,	Maryland	21224		
ore	of He of He If item or oth		20a. Method of Disposition 1 □ Burial 2 △ Cremation 3 □ Removal from State		natory`or other plac	نا نہ		oc. Location - City or			
Baltimore,	permit. Pages 1 and 2 should be filled within Department of Heath and Mendal Hygiene. Important: If item 27 is marked other then eny injury or other treumatic event, IT a M. 2008.		4 □ Donation 5 □ Other (Specify)	Evans Fun	_	, , ,			ll,Maryland		
Ba	Departing Departing Imported on the posterior of the post		21. Signature of Funeral Service Licenseen	y Az 23	aceful Al 25 York F	ternativ Road Ti	es Funera monium, M	l&Cremati Maryland	on Ctr.,P.A. 21093		
			23a. Path. Enter the disease, or complications hat caused shock, or hear failure. List only one cause on each life control of the cause on each life.	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death		
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	V5 C	ANCET	5		Thro MONTH		
L	Examiner			a 901100 quotino 0.7.	/						
	sit A ed	iner	Sequentially list conditions.  If any, leading to immediate  Cause, Enter Underlying  Course Course Course.								
	and and	Examiner	Causa (Disease or injury that initiated events c. Due to (or as	a consequence of):							
3760,	cate be executed physicien and the burial-transit	ical	d								
Box 68	death certificate be executed eattending physicien and and adfor use as the burial-transit	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		7		23d. Date of delivery				
P.O. B		Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year		
	8 5 6	by P	Part II. Other significant conditions contributing to death b					cco use contribute to	_		
ord	w require been si should l	Completed	OHROVIC OBT	FUCTIVE	ZUNG	DIEME	39:	1	obably 4 □Unknown		
Records,	helaw hast ge 2 s	idu					24a. Was an autopsy perform	prior to death?	ompletion of cause of		
ta	en: T tificate tor, pa	<b>a</b>	25. Was case referred to medical			26. Place of Dea	1  Yes 2 th (Check only one)	ZLNo 1 ☐ Yes	2 No		
<u>&gt;</u>	hystci his cer I direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatier		4 🔲 Nursing H	ome 5 🗷 Residen	ce 6 ☐Other (Spe	cify)		
o uc	ling P. After t Tunera	ion;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Da	ry 28b. Time o y Year) Injury	Worl	/at <br Yes 2 □ No	28d. Describe how	r injury occurred			
Division of Vital	To the Hospitel or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injuiding, et	ury - At home, farm, str		165 2 140	28f. Location (Stre City or Town,	et and Number or Ru	ural Route Number,		
Ö	ors after or are Direction										
	• Hosi 24 ho • Fune etely fi	Medical	29a. Certifier (Check only one)  Medical Examiner: On the basis o and manner sta	examination and/or in	n occurred at the tin vestigation, in my of	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner as e and place, and due	s stated. to the cause(s)		
	To th Within To th compl	Me	29b. Signature and title of certifier	~	29c. License			d. Date signed (Mont	h, Day, Year)		
)			) lest voj - a			38635-		2/5/2	007		
	4+1		30. Name and address of person who completed cause of d	Mo.		VORTH PT	. RD.	PORT HOLLA	Ri) (M) 21057		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registr	ar's Signature	parte						

			1 - For State Registrar	State of N	<i>l</i> larylar			nt of H te of L		Mental Hy	giene Reg. No		7 00016
	Physic /Medi		1. Decedent's Name (First, Middle, L Edith	R.			W	loods		2. Date of De Month <b>Januar</b>	Da	2007	3:05 PM
	Exami	ner	4a. Facility Name (If not institution, gi		•				Location of Deat	th		County of De	
	- J. 3		Crofton Convales  5. Social Security Number 6.					fton er 1 Year	If Under 24 Hrs	8. Date of Bir		nne Ar	
	Funeral Director		577-28-6220	1□M 2XF	84	last birthday) Yrs.	Months		Hours Min.		v. Year)	Lvn	Birthplace (State or Foreign Country) Achstation, VA
	P .		Usual Residence of Decedent							2,20,1			
	anylar ehow	_	10a. State 10b. County  MD Prince	George	Boy	ty, Town or Lo	ocation						10d. Inside City Limits 1  Yes 2  No
	the M	Director	10e. Street and Number	George	DOV	v16	104.7	:- Cd-			10- 03	izen of What (	
	h with	al Dir	3903 Embelm Cor	ner				ip Code 0716				ted St	
980	72 hours after death with the Maryland natural', or Items 23e or 28a-1 ehow dical Exat: il vermust terrotified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceder Armed Force: 1  Yes 2 If Yes, Give Year or Dates	s? Į̃No		Was Dec If Yes, sp		spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	-	Black, Wh	mencan Indian, hite, etc. Black
Maryland 21215-0036	.⊆ - ₽	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	r 5+)	16a. Dece (Give life.	dent's Us kind of w DO NOT	ual Occupa rork done di use retired)	tion uring most of wo	rking	16b. K	ind of Busines	ss/Industry
21	e filed with Il Hygiene. other ther		12			Admir	nistr					.vate	
and	ould be fi Mental H arked ott	Be	17. Father's Name (First, Middle, Las	t)						me <i>(First, Middle,</i> Hewitt	Maiden	Sumame)	
Ž	2 should be and Menta le marked aumatic ev	ဥ	Andrew Merritt  19a. Informant's Name/Relationship	(Type, Print)		19b Mailir	ng Addres	s (Street a		ural Route Numbe	er City o	r Town State	Zin Code)
	A 10 = 3		Deborah White ( D.	. ,				em Co		owie, MD			, <i>Lip</i> 0008)
Baltimore,	m O		20a. Method of Disposition	70	20b. F	Place of Dispo cemetery, crer	sition (Na	ame of other place	) I	Date	20c. Lo	cation - City	or Town, State
<u><u>E</u></u>	Pages ment of ant: If it ury or o		14∑ Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec		0	ct Line				6/2007	Bren	twood,	MD
Salt	permit. Page Depertment. Important: If eny Injury o		21. Signature of Funeral Service and	nsee						rt Linco			
	<b>₹</b> 0 ⊆ € a		Rechard Shorts	_eL						Road Br		rood, M	ID 20722
1	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	h. Do not ent 1 <b>ythmi</b> a		ede of dying	, such as cardia	c or respiratory ai	rrest,		Approximate Interval Between Onset and Death
13	/Medical Examiner		resulting in death)	Due to (or a	is a conseq	uence of):							
		er	Sequentially list conditions, if any landing to immediate	b. Due to or a	is a cons	uence of							
	tificate be executed go physicien and as the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
oʻ	exection and arrival-tr	Exe	resulting in death) Last	Due to (or a	s a conseq	uence of):							
68760,	ate be hysici the bu	edical		_ d									
.O. Box 6	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	I death 3	Ectopic (	pregnancy			1	23d. Date of d Month	elivery Day Year
۵.	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying	cause give	n in Part I.	23e. Did to	obacco u	se contribute	to the cause of death?
of Vital Records,	quires an sign uld be		Failure to	thrive						101	/es 2{	No 3□F	Probably 4 Unknown
O O	aw requir s been si 2 should I	Completed	Dementia							24a. Was		24b. Were a	autopsy findings available
Ĕ		mo								autop perfo 1 Yes	rmed? 2∰ No	death?	completion of cause of
ita	ysicien: Is certificel director, p	BeC	25. Was case referred to medical examiner?						26. Place of Dea	ath Check only o		10 10	20110
7 \	× 5	은	1 ☐ Yes 2 No			ER/Outpatien			4X I laursing F	lome 5 ☐ Resid	lence (	3 □Other (Sp	pecify)
ono	Attending Production of death.	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of in (Month, C	jury Jay Year)	28b. Time of Injury	М	28c. Injury Work? 1 ☐ Y	at ? es 2 □ No	28d. Describe h	now injur	y occurred	
Division	P the C	Certification;	3 Suicide 6 Could not be determined	289. Place of I	njury - At ho	ome, farm, str	eet, facto	ry, office		28f. Location (S City or Tou	Street and yn, State	d Number or F )	Rural Route Number,
	ne Hospital 24 hours a ne Funeral C	edical	29a. Certifier 1 Certifying P (Check only one) 2 dical Exa	hysician: To the bes miner: On the basis and manner:	of examina	wledge, death tion and/or inv	occurre vestigatio	d at the time n, in my opi	e, date and place nion, death occu	and due to the curred at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of cartifier				29	c. License	number			-	nth, Day, Year)
			M					D 570	28		2/	4/2007	
	Y		30. Name and address of person who Aditya Chopra,			gely		Suite	231	Annapoli	s, M	D 2140	1
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	0.00	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9865 3-1-07 vt.
State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 5:30AM<sub>M</sub> Lester Iola Walls Feb 4. 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bradford Oaks Nursing Home Clinton Prince George's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 577-92-3166 **Funeral** Days Hours <del>65 9168</del> Yrs 87 March 7, 1919 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Me. K.al Examiner must be notified at 1 ☐ Yes 2 No Prince George's Clinton Maryland Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 7520 Surratts Road 20735 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Widowed 4 □ Divorced Specify. Completed by Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Oscar Kerrick ပ Mary Agnes Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print)
Richard A. Walls (Son) 6116 Ivy Hill Ct. Hughesville, Maryland 20637 20b. Place of Disposition (Name of cemetery, crematory) of biher Glabe) Cem. Fe Bate 10, 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State Brnadywine, Maryland Union BethelMeth. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral 9 70015 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Trusing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Saltimore, Maryland 21215-0036

State Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 12070 WISOTSIU 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



Medical

29c. License number

29d, Date signed (Month, Day, Year,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** JoAnn Mary Wright 3 2007 4c. County of Death ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1115ta ai lata If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 578 60 1011 Director Dec 4, 1944 Washington DC Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland | Charles Bryans Road 10g. Citizen of What Country? 10e. Street and Number ms 23a or 2 must be n 6743 Amherst Road 20616 United States 14. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2FT No If Yes, Give XX Year or Dates: 1 Never Married 2 Married marked other than "natural", or imatic event, the Medical Examii 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo William Marcopulas ٩ Rita Marie Callow 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tra Michelle D. Aceto (daughter) 6640 Bucknell Road, Bryans Road, Maryland 20616 be of Disposition (Name of Date 200. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 7, 2007 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service L MOJ284 Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Heart Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Hypertension Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign be ( atrial fibrillation diabetes ¹ X Yes 2 □ No 3 □ Probably 4 □ Unknown Chronic Kidney disease 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy prior myocardial 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To ours after death. neral Director; After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician:

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Ravinder Sindhwani Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

FEB 0 6 2007

Sinalwani

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD 11350 Pembrook Sq, Suite 304, Waldorf, MD 20603

29d. Date signed (Month, Day, Year)

February 4th, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar			of Health and of Death	Mental Hy	giene Reg. No.	07	03349
	Physici /Medi		1. Decedent's Name (First, Middle, La	ninia Wi	'Ison			2. Date of D Month	aath 30 - O	Year <b>7</b>	3. Time of Death 12:30 M
9	Examir		4a. Fecility Name (If not institution of	Rossuil	le In yrs. last birthday	B	own, or Location of Dea Year II Under 24 Hr.	S. R Date of B	4c. County		ace (State or Foreign
	<ul><li>Funeral</li><li>Director</li></ul>			1□M 2 <b>万</b> F	13 Yrs.		Days Hours Mir		ay, Year) 33	Mar	ace (State or Foreign ry) Yland
	death with the Maryland me 23a or 28a-1 show r must be notified at	ž	10a. State 10b. County	1	Oc. City, Town or I			-		10	od. Inside City Limits  1
	r 28a-f	Director	10e. Street and Number		Dayth	more 10f. Zip C			10g. Citizen of		
	ath with	ralD		wood Au	enue	2	1213		US		
036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. It may be 71 is marked other than "naturel", or Iteme 23a or 28a-1 show other traumatic event, I'm Medical Expriner must be notified at	by Funeral	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	erin U.S. 13	I. Was Decede If Yes, specif	int of Hispanic Origin? ( y Cuban, Mexican, Pue No Specity:	Specify Yes or N rto Rican, etc.)	Specif	e - America ck, White, e	
21215-0036	within 72 ho ene. than "natur	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation rade completed)  College (1-4or 5+)	16a. Dec (Giv life.	edent's Usual re kind of work DO NOT use	Occupation done during most of we retired)	orking	16b. Kind of B	usiness/Ind	ustry
	filed wil Hygien other th		17. Father's Name (First, Middle, Las.	/ 1.11/	1/1	Jer	18. Mother's Na	ame (First, Middle	Maiden Suman	LSe	cuardy
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, the Mental Control of the Mental	To Be				Non Addison (	Ne	llieh	)i150,	0	-
, Mai	and 2 sho ealth and n 27 is mu		Dennis Wi	150 N 50N	11100		Street and Number or F LISON AC	re, Ba	Jも人	State, Zip	1206
Baltimore,	permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is m eny injury or other traum once.		20a. Method of Disposition 1  Burial 2  Cremation 3   4  Donation 5  Other (Speci	Removal from State	20b. Place of Disp cemetery, ch	position (Name ematory or oth	of ler place)	2 /5/m	Post H	City or Tov	wn, State
Balti	permit. Departrimporta eny inju		21. Signature of Funeral Service Lice	Insee Sri	7	Wame and	Address of Facility	Ne Fu	weral.	Ser	ites
£ .	24		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the one cause on each line.	e death. Do not e		, .	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. End Due to (or as a o	Stapo	, au	menti.	ς			0.100. 4.12 504.11
	Examiner	_	Sequentially list conditions,	b							
92,	executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	unsequence of).						
,8760,	be	edicai Exa	resulting in death) Last	Due to (or as a d	onsequence of):						
9		/Medi	IF FEMALE:	23c. If yes, outcome of	oregnancy				024.0		
P.O. Box	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□No 9 □ Unknown	1 Live birth 2 ( 4 Pregnant at tire 9 Unknown	Fetal death 3	□Ectopic pred □ Other (spec				te of deliver inth	y Day Year
	w requires that the de been signed by the a should be detached f	þ	Part ii. Other significant contributing to death but not resulting in the underlying cause given in Part i.								
I Records,	sician: The law re certificate has be irector, page 2 sho	Completed				· · · · · · · · · · · · · · · · · · ·		24a. Wa: auto perf 1 ☐ Yes	psy ormed?	Were autop prior to com death? 1 \( \text{Yes} \)	isy findings available inpletion of cause of
Sital	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:	0 T T T T T T T T T T T T T T T T T T T			eath (Check only			
W. j	Attanding Physician: r death. ector: After this certifications the funeral director.	lon: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  ↑ ☐ Natural 5 ☐ Pending	1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatie 28b. Time (ear) Injury		Other: 4 Nursing c. Injury at Work? 1 Yes 2 No		how injury occur		)
السالك) Division of	D Har	Certification:	2 Accident investigation 3 Suicide 6 Could not to determined	De Place of Injury	- At home, farm, s Specify)			281. Location City or To	(Street and Numb wn, State)	er or Rural	Route Number,
-01V	Hospital	Medical C	29a. Certifier (Check only one)  Certifying P  2 Medical Exa	hysician: To the best of r miner: On the basis of ex and manner state	amination and/or i	ath occurred at investigation, i	t the time, date and place n my opinion, death occ	e, and due to the curred at the time	cause(s) and ma , date and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				License number	0	29d. Date signe		
	Λ.		30 Name and address of access via	ocompleted cause of dear	h (Item 222) (Tree		5697	7	Teb :	, 16	Tuck
_	H			rdon 78	VS 60	alcwdd	d Ray a	Len B	urnse,	40	21042
	Sta Regist	_	31. Date filed (Month, Day, Year) FEB 0 6	32. Registrar's	Signature	deser!					

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Veronica Waight Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Strai Hospital Bultimore BUHSMORE waret If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 12, 1944 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 💢 F 094-38-7905 62 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director N/A Maryland Baltimore Ceronice 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Example. 2095 Rock Rose Avenue 21211 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 215-0036 1 ☐ Yes 🌠 No If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced 99 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maid 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last, Be Julio Blasetti Mary Silvia ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) actient Elaine Sheridan, Sister 104 Begonia Place Ventura, California 93004 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 02/05/07 Baltimore, Maryland 21. Signature of Funeral Service Unersee
Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arrhyth mia Cardiac **Physician** /Medical Due to (or as a consequence of): Examiner raset Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes Completed 24a. Was an has page 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? After t To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide

days 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No performed' 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 65000 31/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singi Hospita

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 XYes 2 No

New York

2007

**USA** 

14. Race - American Indian,

Black, White, etc.

Specify: White

N/A

3

Medical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

ndan M. Cumm

MM INS 32: Registrar's Signature

29a, Certifier

State

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February Elbert Wolf John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 85 Director 214-16-1784 Aug 28, 1921 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f sh ner must be notified Directo Phoenix Maryland **Baltimore** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14407 Manor Road 21131 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces: 1 Mayes 2 □ No If Yes, Give Year or Dates: 1942-46 1 ☐ Never Married 2 Married 1∐Yes 2∏XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Civil Engineer Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wolf Daisy **Wolfe** ပ Roscoe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14407 Manor Road, Phoenix, Maryland Ethel M. Wolf/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Immanuel Lutheran Cemetery Manchester, Maryland 21. Figure 14 Fune 17, envice Licens 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each life. Immediate ause (Fi / I disease or inditio resulting in Ammai **Physician** /Medical Due to (or as a consequence of): Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed

physician and is the burial-trans

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Physician/Medical þ Be Completed

that initiated events resulting in death) Last IF FEMALE: 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STUKP 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 🗖 Natural 5 Pending investigation

2 Accident

3 Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death

1 npatient

28a. Date of Injury (Month, Day Year)

Due to (or as a consequence of)

Due to (or as a consequence of).

4☐Pregnant at time of death 9□Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

Pulmonay diseast

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> Month Day

23d. Date of delivery

1 | Yes 2 | No 3 | Probably 4 Unknown

24a, Was an autopsy performed?/ Yes 2 No 1∏ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier Cuntina

6 ☐ Could not be

29c. License number D0051341

1 Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

OCIANO MI) 6701 N. Charles St. Baltimore MD 21204 9

Year) 31. Date filed (Month, Day,

FEB 0 6 2007 32 Begistrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Medical

State Registrar

**ORIGINAL** 

23e. Did tobacco use contribute to the cause of death?

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🙀 No

Maryland

5:21p M

2007

USA

Specify:

14. Race - American Indian,

White

Black, White, etc.

Highways

Year

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month 2:10 P. M 28, 2007 Robert Duvall White January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner 6407 Stoneham Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2∏ F Director 579-10-3149 87 13, 1919 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 6407 Stoneham Road 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Folces: 1 Gyes 2 □ No If Yes, Give Year or Dates: 1941-61 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: Specify: 3 Widowed 4 ☐ Divorced White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Division Chief Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul White Mary Duvall Scaggs ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne H. Johnson / Daughter 123 Myrtle Ridge Rd., Lutz, Florida 33549 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bethesda, Maryland Montgomery Crematorium, Inc. 4, 2007 21. Signature of Funeral Service Licensee Robert A. Punphrey Tuneral Hone/Bethesda-Chevy Chase, Inc. M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the dise (se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Life only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** small cell lung cancer disease or condition resulting in death) 11 weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43083 January 29, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15+1

Registrar DHMH 17 Rev 1/2001

State

Sotos, M.D.,

32. Resistrar's Signature

George A.

31. Date filed (Month, Day, Year)

9707 Medical Center Drive #300, Rockville, Maryland 20850

			1 - For State Registrar	State of Ma	ryland / De	partment		and Me	ental Hygie	_		33	53
		**	1. Decedent's Name (First, Middle, Last)						2. Date of Death			3. Time of	Death
	Physici		Marie Salvato	ora Young					Jan. 31,		ar	6:45	A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, To	own, or Location		Julie Ji	4c. County of 0			
	LAditiii	C1	Manor Care Ru	urton		,	Towson			Balti			
	Euparal		5. Social Security Number 6. Sex		(In yrs. last birthda			er 24 Hrs.	8. Date of Birth		Birthplac	e (State or	r Foreign
	Funeral Director			M 2∏F	101 Yrs.	Months	Days Hours	Min.	pril 1,	(ear) 1905	Country, Mary	e (State or	
			Usual Residence of Decedent					1 7	P 1,	1703	id I y .	Lana	
	/lanc		10a. Slate 10b. County		10c. City, Town or	Location					10d.	Inside Cit	y Limits
	Man	to	MD Balti	imore	Towson							1 🗌 Yes	2 🛛 No
	289	Director	10e. Street and Number	1		10f. Zip C	Code		100	. Citizen of Wha	i Country	?	
	3a o		7001 N. Charles S	Stroot			212	204		USA	٨		
	ne 2;	Funeral		2. Was Decedent E	ver in U.S.	. Was Decede			ofv Yes or No-	14. Race - /		Indian.	
	ter d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No		If Yes, specif	int of Hispanic C by Cuban, Mexic	an, Puerto R	lican, etc.)		Vhite, etc		
36	Irs a	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>∑</b>	No Specif	'y:		Specify:	Whit	te	
ŏ	within 72 hours after death with the Maryland ene. Than "netural", or flems 23s or 28s-f show the Medical Examiner mant for motified at	Completed	15. Decedeni's Educ	ation	16a. Dec	edeni's Usual	Occupation		16	b. Kind of Busin	ess/indus	itry	
5	in 72	plet	(Specify only highest grade	completed)	(Gir	e kind of work  DO NOT use	done during mo	ost of working	g				
7	with iene the	E	Elementary/Secondary (0-12)	College (1-4or 5+ N/A		etaker				Careg	izzino		
0	filed v I Hygie other I		17. Father's Name (First, Middle, Last)	11/21	Jai	CLARCI	18. Moti	her's Name	(First, Middle, Ma		r v TITE	<del>-</del>	
a	d be antal	To Be	Augustine Russo				ъ	Rosina	Russo				
2	should nd Men marke umatic	Ĕ	19a. Informant's Name/Relationship (Typ	na Print)	19b Ma	ilina Address (			Route Number, C	City or Town Star	te Zin Co	orfe)	
				,						-/		,00,	
ຜົ	Heal Heal		Daniel W. Kelly  20a. Method of Disposition		20b. Place of Dis	position (Name	e of		Reston,	VA ZUI94 c. Location - City		Slate	
چ	Pages nent of ant: If it		1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	New Cat	hedraI	nerplace)	Feb. 2		·			
Baltimore,	교 는 근 중		*4 □Donation 5 □ Other (Specify)	-	Cemeter			200		Baltimo			
a	Departing Impo		21. Signature of Funeral Service License		1	emmon F	uneral	Home of	of Dulan	ey Valle	ey, I	inc.	
	40200		Co. N	ichael J.	Flagle <sub>1</sub>	0 W. Pa	idonia R	Road T	imonium,	MD 2109			
	14 (A)		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	e cause on each line	ne death. Do not e ).	nter the mode	of dying, such a	is cardiac or	respiratory arres	t,	Ini	oproximate lerval Betw nset and D	reen
	Physician		Immediate Cause (Final disease or condition	CERE	BROVA	15CU.	LAR	THIN	ROMBO	0515	0	nset and D	oatn
₹34	/Medical		resulting in death)	Due to (or as a	consequence of):							Mon.	This
Н	Examiner		Sequentially list conditions,	and	STRO	KE							
	D ==	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):								
	nd rans	аш	that initiated events C.										
,60	e be executed /sicien and e burial-transit		resulting in death) Last	Due to (or as a	consequence of):								
		cal	d.										
9	The law requires that the death certificate tite has been signed by the attending phy bage 2 should be detached for use as the	by Physician/Med	IF FEMALE:								-5		
Вох	th ce r use	an/	23b. Was decedent pregnant 23	3c. II yes, outcome o 1 ☐ Live birth 2		□Ectopic pre	опапсу			23d. Date of			
H	dea ne ati	Sicia	in the past 12 months? 1 ☐ Yes 2 No	4 Pregnant at ti 9 Unknown		Other (spec				Month	Da	y Y	ear
о. О	at the de by the a tached	h	9 Unknowń	3LI CIRTOWII									
ທົ	w requires that been signed to should be deta	by F	Part II. Other significant conditions cont	tributing to death but	not resulting in the	underlying cau	use given in Part	t I.	23e. Did tobac	cco use contribut	e to the c	ause of de	ath?
2	an si								1 🗆 Yes	2 □ No 3 □	] Probably	y 4 509	nknown
Records,	s be	Completed							24a. Was an	24b. Were	autopsy	findings a	vailable
ř	The tay te has age 2:	E							autopsy	d? deat		etion of ca	use of
		BeC	25. Was case referred to medical				26 Plac	ce of Death /	(Check only one)	No 1 1 1	165 21	7 140	
>	ysici is cer direc	0	examiner? 1 ☐ Yes 2 WNo	ospital:	2 ER/Outpati	ent 3 DOA	0		e 5 Residenc	e 6 □Other /9	Speciful		
0	Phy eral c	ij	27. Manner of Death	28a. Date of Injury	28b. Time	of 280	c. Injury at Work?		d. Describe how		poony,		
Division of	ith. :: After e funera	te le	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	М	work? 1 ☐ Yes 2 ☐	□No					
/18	Attendi r death. sctor: A by the fu	Certification:	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm,	treet, lactory,	office	28	Bl. Location (Street		r Rural Ro	oute Numb	oer,
S	d in t	ert	4  Homicide determined	building, etc.	(Specify)				City or Town, S	State)			
	spit nera fille		29a. Certifier 1 Certifying Physi	ician: To the best of	my knowledge, dea	ath occurred at	the time, date a	and place, an	nd due to the caus	se(s) and manner	r as state	d.	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only one) Medical Examination	er: On the basis of e and manner state	xamination and/or	investigation, in	n my opinion, de	eath occurred	d at the time, date	and place, and	due to the	e cause(s)	
	To the form of the comp	Ž	29b. Signature and title of certifiers	/			License number			. Date signed (M	onth, Day	(, Year)	
	/		111/02/2	din		2	-0012	849	2	1-31.	-07	7	
1	1		30. Name and address of person who con	npleted cause of dea	ath (Item 23a) (Type	e. Print)					-		
1			AH. GAIL ADI.	M.D.	7600 C	ISCE.	R Dr	10	WSON	MD	212	204	p <sup>t</sup> l
>	Sta	te	31. Date liled (Month, Day, Year)	32. Begistrar		1-6-							
	Registr		FEB 0 6 200	37 Brogins	, 1. A	See I							

68760. Box Division or Vital Records, P.O.

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State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MD

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

64

2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year LLARDS ANDA JALLOH JANUARY 21 2007 04:52-AM Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ADVENTIST KOCKVILLE, MARYLAND MONTGOMERY HADY GROVE HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 38 Months Hours 1 □ M 2 X F NONE Yrs MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20912 United States 7600 Maple Ave #1506 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None None 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jide Allards <u>Zainab Dainkeh Mansaray</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Maple Ave #1506 Takoma Park, MD Jide Allards/Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20a. Method of Disposition Date 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Cemetery \* 4 ☐ Donation 5 ☐ Other (Specify) 1/24/2007 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. M00956 933 Gist Ave., LL, Silver Spring, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death NBCRU7121NG BNTBAOCULITIS Due to (or as a consequence of): 38 DAYS CXTREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MULTI-ORGAN SYSTEM 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

**Examiner** the death certificate be executed and burial-tran P.O. Box 68760. attending physician the as esn ğ the detached þ been signed be should be deta Division of Vital Records, cate has page 2 s certificate or Attanding Physician: : After this funeral of death. To the Funeral Director: , completely filled in by the t within 24 hours after

**Physician** 

/Medical

Director

ģ

Completed

Be 2

Examiner

**Funeral** 

Director

Itam 27 is marked other than "natural", or Itams 23e or 28a-f show other traumatic event, the Medical Executing regardless relitied at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than any injury or other traumatic event, Itam

**Physician** 

/Medical

Examine

Physician/Medical

þ

Completed

Be

2

Certification:

Medicai

29a. Certifier

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar 31. Date filed (Month, Day, Year)

JAN 23 2007

ROBERT

29b. Signatura and title of certifier

JEH-RAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENWALD

and manner stated

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MB

29d. Date signed (Month, Day, Year)

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fb 9864 2-12-07 pt State of Maryland Department of Health and Mental Hygiene For State Registra MFND#1, 23I+IIperMD1/23/07, PMW, MOO Certificate of Death 1. Decedent's Name (First, Middle, Last) Imtiaz 2. Date of Death 3. Time of Death Uddin Ahmad **Physician** Month Day 13:32 M 19 2007 ANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Director 67 JUL 2, 1939 India 086-36-83<del>66</del> Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location show 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 8811 Cipriano Court 20706 United States Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Asian ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University of 5+ Economics Professor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ashfaq Uddin Ahmad ဂ Zubeda 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sameer Imtiaz Ahmad/Son 1300 Lincoln Woods Dr., Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland National 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 1/20/2007 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD M00956 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC BRAIN INJURY 1 day /Medical Due to (or as a consequence of): Examiner ARRHYTHMIA YEAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specity) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed STROKE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No spital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, pa 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 Nack akhe 19. 2007 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET NAIK 600 NORTH WOLFE BALTIMORE. MD 31. Date filed (Month, Day, Year) **JAN 23** egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rachael Austin January 1020 AM Turner 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot Hospital at Eastor Memorial Easton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fiction March 16, 1920 Mary land Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ VF 214-18-420 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Talbot Royal Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street-P.O. BOX144 56 Gate U5 A Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 □ Divorced Specify. Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOK Keeper Family Business 12 17. Father's Name (First, Middle, Last) 18. Molher's Name (First, Middle, Maiden Surname William Aurbrey Turner Carroll Jane 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Royal Oak, Maryland 21662 5675-Gate Laura 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Loca ion - City or T. wn, Slate 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Richards MemiPark 1/27/07 Easton, 22. Name and Address of Facility Home, P. A. Henry Funeral Home, P. A. 21. Signature of Funeral Service Licenses Sie washington St. Cambridge 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cerebrovascular accidents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 № 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) njury occurred

attending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, certificate has been signed by the rector, page 2 should be detached efter death. filled in by within 24 hours er
To the Funeral D
completely filled i

**Physician** 

/Medical

Examiner

Director

þ

Completed

Be

**Funeral** 

Director

and Mental Hygiene. Is marked other than "natural", or Itams 23s or 28s-f show raumatic svant, <u>The Medical Examinar must be notified at</u>

.. Pages 1 end 2 should be fil tment of Health and Mental H tant: If itsm 27 is marked oth ijury or other traumatic svsn

**Physician** /Medical

Examiner

Physician/Medical Examiner

215-0036

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Maryland

ed p			1 ☐ Yes								
Completed			24a. Was an autopsy performed 1  Yes 2  ■								
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one									
To	1 Yes 2 No	Hospital: 1 Anpatient 2 ER/OutpatienI 3 DOA Other: 4 Nursing	Home 5 ☐ Residence								
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of lnjury 28c. Injury at Work?	28d. Describe how i								
Certification:	3 Suicide 6 Could not to 4 Homicide determined		28f. Location (Street City or Town, St								
Medical C	29a. Certifier Check only one) Certifying Pl	niner: On the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause urred at the time, date								
W	29b. Signature and title of perfiles	alle mo 29c. License number D 35 28	4 1								

e(s) and manner as stated. and place, and due to the cause(s) 29d. Daje signed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print)

washington St Easton mo 21601

and Number or Rural Route Number,

Registrar

32. Registrar's Signature

			for State Registrar	State o	f Marylai	nd / Dep <i>Ce</i>	artment of H rtificate of	lealth a Death	and Mental H	ygier Reg. N	Sime for the	7	03358
			1. Decedent's Name (First, Middle, Last)  2. Date of Death										3. Time of Death
	Physic /Medi		Ethel Ar	lene Al	hee				Janua		8,2007	ear	8:45P M
1	Exami		4a. Facility Name (If not institution				4b. City, Town, o	r Location of			c. County of	Death	0.451
			Mallard Bay Car	re Center			Cambr.	idae			Do	rches	tor
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		Birth	9	Birthplace	e (State or Foreign
	Director		132-12-4834	1□M XXF	87	Yrs.	Months Days	Hours	Min. (Month, April	Day, Yea 15.1		(Country New Y	
	<b>B</b>		Usual Residence of Decedent	,									
	Maryland -f ahow		MD 10b. County	orchester	10c. C	ity, Town or Lo						1	Inside City Limits
C	Ba-f.	cto	MD	Chester		Callic	ridge				XXYes 2 □ I		
2	or 2	Funeral Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	t Country	?
3	23a	rai	216 Market Squ	are			2	1613			US		
P	ems ems	Ine	11. Marital Status	12. Was Deci	edent Ever in U prces?	J.S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify Yes or b, Puerto Rican, etc.)	No-	14. Race -	American White, etc.	Indian,
36	or It	by Fu	1 ☐ Never Married 21 Marr	If Vac Gi	2∭No ve		1 ☐ Yes 2 <b>XX</b> No	Specify:	,		Specify:	Whi	to
21215-0036	ural',	p	3 Widowed 4 Divorced	1,500	ates:						орвену.	AATIT	
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	liled 1 Tygie ther nt.	ပိ	17. Father's Name (First, Middle,	( act)		BOC	kkeeper	10 Matha	or's Name (First, Midd	Un Adminis		lege	
Maryland	ntal I	Be	Albert Ammer	·-							an Sumame)		
Ë	d Me d Me mark matic	10	19a. Informant's Name/Relations			405 14-10			able Cher				
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	1 and 1 eath 1 mm 2 ther		Nathaniel E. Al 20a. Method of Disposition	bee Husb		5 Ca	mortage \	/1 IIag	ge Lancaste				
ō	T it of		Burial 2 Cremation	XX Removal from	State	cemetery, crei	matory or other plac	,			Location - Cit		
Ë	Tant tant		4 □Donation 5 □ Other (S		Nis		1 Cemete	- 1	/25/2007		thleher	n, PA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ahov any injury or other traumatic event, the Medical Examinar must be notified at ance.		21. Signature of Funeral Service	Licensee		T	Name and Addre Nomas Fur	ss of Facilit neral	Home, P.A				
	403 e a		Janes &	not a second			00 Locust	: Stre	<u>et Cambri</u>	lge,	Maryla	and 2	1613
			23a. Part VEnter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the dear ach line.	th. Do not en	er the mode of dyin	g, such as	cardiac or respiratory	arrest,		Int	proximate erval Between
į,	Physician		Immediate Cause (Final disease or condition	De	mein	tia.						On /	O (100 CS
1	/Medical Examiner		resulting in death)		(or as a consec								years.
	Lxammer		Sequentially list conditions.	b									
	D iii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (	or as a consec	quence of):							-
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8760,	cate be executed physicien and ; the burial-transit	E E	rooming in south, East	Due to (	or as a consec	quence of):							
87	hysic the b	dicai		d								_	
9	ing p	(a) t	IF FEMALE:						-				
Вох	death certifi e attending d for use es	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	come of pregna irth 2  Feta		Ectopic pregnancy	r			23d. Date of	-	
	e de the a	Sic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregn 9☐Unkno	ant at time of c	death 5	Other (specify)				Month	Day	/ Year
P.0	d by etach	Physician/M		1.									
Ś	The law requires that the death certific sie hes been signed by the attending p page 2 should be detached for use as	۾	Part II. Other significant condition	ins contributing to de	eath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Dio	l tobacco	use contribut	te to the ca	ause of death?
Records,	w requir been si should	Completed							1	]Yes 2	2 □ No 3 □	] Probably	4 □Unknown
ec.	e law r hes be	pie							24a. Wa		24b. Were	autopsy	findings available
Œ	The ate h page	E O							per 1 Yes	opsy formed? 2 X N	deat	to comple h? Yes 2⊡	etion of cause of
Vital	ysician: The is certificate hi director, page	0	25. Was case referred to medical					26. Place	of Death (Check only	_/\	0 1	165 2	INO
<b>&gt;</b>	Physician: this certificatal director, I	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 □ I	npatient 2	ER/Outpatien	t 3 DOA Oth		rsing Home 5 Re		6 □Other (5	Specify)	
			27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time of	28c. Injun Worl		28d. Describe			opocity)	
Ö		atio	1 Natural 5 Pendin 2 Accident investig	9	n, Day 16ar)	Injury		Yes 2∐N	10				
Division	or Attendation distriction of Attendent Director: in by the	ific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 288. Place	of Injury - At h	ome, farm, str	eet, factory, office		28f. Location	(Street a	nd Number o	r Rural Ro	ute Number,
Ö	safter safter ni Direct	Certification:	4 El Horniolog	Duildii	ng, etc. (Specil	<b>y</b> )			City or I	own, Stat	(8)		
	pspil hour iner		29a. Certifier 1X Certifyin	g Physician: To the	best of my kno	wiedge, death	occurred at the tin	e, date and	place, and due to th	e cause(s	s) and manne	r as stated	1.
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	(Check only 2 Medical one)	examiner: On the ba	asis of examina	uon and/or inv	estigation, in my o	oinion, deat	h occurred at the time	, date an	d place, and	due to the	cause(s)
	To t To t com	Σ	29b. Signature and title of certifier		1		29c. License	number		29d. Da	ate signed (M	onth, Day,	Year)
			galine	lan.	00		HAME	5997	3	11	19/10-	7	
			30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type,	Printh			1	. //0	-	
			Patricia A.	Johnson	00	100	Bram	ble	Street	am	bridge	· MY	21/12
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa		1 4				9	7/11	ر الهاب
	Registr	ar	JAN 2	& ZUU/	Weller a	A. S.	Choales)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 21, 2007 Mae Armiger 9:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14811 Candy Hill Road Upper Marlboro Prince George's 8. Date of Birth (Month, Day, May 12, 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs.

Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months 1□M 2X□F 579-40<del>-</del>0108 77 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14811 Candy Hill Road 20772 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Assistant Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles C. Dixon Maude Elizabeth Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14811 Candy Hill Road, Upper Marlboro, MD 20772 James R. Armiger - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of It Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans' Cemetery 1-29-2007 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3035 Old Washington Rd. M00053 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 □ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division or Vital Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Sesidence 6 □Other (Specify) Certification: To this funeral 27. Manger of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 ☐ Pending investigation 1 Yes death. 2 ☐ Accident Director: 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C 29a. Certifier 🗺 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

ne and addre

31. Date filed (Month

Registrar

of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] ] 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Gaston 20 07 1:55 AM /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month), Days Hours Min. (Month), Days Xear) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
N. Carolina **Funeral** 1XM 2□F 79 Yrs. Director 249-38-2662 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Madical Exertings froughts at Completed by Funeral Director MD Montgomery Silver Spring 1 ☐ Yes 2 X No 28a-f the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō 807 Silver Spring Ave 20910 or items 23a USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: black 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Brick Masonry Construction wermit. Pages 1 and 2 should be filled. Department of Health and Mental Heritaportent: If them 27 is more any injury or other. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Walter Blue Mae Catherine Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
807 Silver Spring Ave Silver Spring MD 19a. Informant's Name/Relationship (Type, Print) Darryl Blue/ son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State North 1 Burial 2 □ Cremation 3 ☐Removal from State \* 4 □ Qonation 5 □ Other (Specify) Piney Grove Cem 1/27/07 Maxton, Carolina 21. Signature of Funaral Selvice Licens ame and Address of Facility 420 H Street K Henry Funeral Chapel Wash DC 20002 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit Cause (Disease or injust that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 2 20 1 Yes 1 Yes Be 25. Was case referged to medical 26. Place of Death (Check only one examiner' 1 Yes 2 No Other: 2 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Inpatient 3 DOA 28a. D. e of Injury (Month, Day Year) Certification: 27. Manfier of Death 28b Time of 28c. Injury at Work? After 28d. Describe how injury occurred Natural 2 Accident 5 Pending Director: investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely tilled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Day, Year) 0 Name and address of person no con leted cause of death (Item 23a) (Type, Print) Registrar's Signature State JAN 24 2007 Registrar

			1 - For State Registrar	State of M	aryland / Depa	artment of rtificate o				giene Reg. No.	007	03361
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic	al	Hortensia Juana						01	20	2007	6:45 A M
	Examir	er	4a. Facility Name (If not institution, give s Forest Glen Nursin			4b. City, Town					County of Dea	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. last birthday)	If Under 1 Yea		24 Hrs.	8. Date of Birt	h .	ntgome 9. Bir	tholace (State or Foreign
L	Director		578 <b>-</b> 40 <b>-</b> 4475	M 2 1 7	76 Yrs.	Months Day	s Hours	Min.	8. Date of Birt (Month, Dat 02/21/1	930	Ne	W York
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits
	Maryll f sho	2	MD Montgome	cv	Silver S							XXYes 2 □ No
	r 286	ireci	10e. Street and Number	- 1	DIIVCI D	10f. Zip Code				10g. Citiz	en of What Co	ountry?
	th with	Funeral Director	2700 Barker Stree			209	901			U	.s.A.	
	ens lems	ıner	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Yes, specify Cu	Hispanic Ori	igin? (Sp	ecify Yes or No-		4. Race - Ame Black, Whi	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	No	15√Yes 2□N			rto Rica	- 1	Specify:	
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2	filed wit Hygiene ther the	Completed		4 years	Rec	gistra N	lurse			Di	strict	of Columbia
ind	be fill tal H	Be	17. Father's Name (First, Middle, Last)  Ignacio Smith						e (First, Middle,			
Maryland	should to a marked umatic e	To	19a. Informant's Name/Relationship (Ty.	na Print)	19h Mailir	a Address (Stra	Clem		La Hern			Tin Code)
	01 00 00 00		Maria B. Reynolds							. ,		I. MD 20901
altimore,	is 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	lace)		Date Date		ation - City or	
Ē	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Heaven	+	1/24	/2007	Silve	er Spr	ing MD
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4594 Beech Road; Temple Hills, MD 20748  23a. Part Inter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E onset a disease or condition  A THERD SCLEROTIC CARDIOVAS CULAR DISEASE  I Memorial and the cause (Final disease or condition)  A THERD SCLEROTIC CARDIOVAS CULAR DISEASE											Approximate Interval Between Onset and Death	
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	nd ransi	Examiner	that initiated events									
8760,	rate be executed thy sician and the burial-transit	EX	resulting in death) Last	Due to (or as	a consequence of):							
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Box (	es that the death certific igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						23	3d. Date of del	iverv
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Division of Vital Records,	Attending Physicien: The ir death. ector: Atter this certificate haector: Atter this director, page by the funeral director, page	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1{	□Yes 2□I	No				
$\overline{\leq}$	# 0 0 >	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury · At home, farm, stre c. (Specify)	et, factory, office	€		28f. Location (S City or Tow		Number or Ru	ural Route Number,
_	To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b		29a. Certifier 1X Certifying Phys	ician: To the best	of my knowledge, death	occurred at the	time, date an	d place	and due to the c	ausa(s) a	nd manner as	stated
	ne Ho ne Fur ne Fur	edical	(Check only 2 Medical Examination)	er: On the basis o and manner st	t examination and/or inv	restigation, in my	opinion, dea	th occurr	red at the time, d	late and p	lace, and due	to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier				nse number			,	signed (Monti	
			Chowdley,	mo		D4	3121			1/2	0/07	Z
	(5)		30. Name and address of person who co	mpleted cause of d	leath (Item 23a) (Type,	Print)	BUD-	TON	SVILLE	, M	208	66
	Sta	te	31. Date filed (Month Day, Year)	32. Registr	ar's Signature	7~110/	14					-
	Registr		31. Date filed Mooth 2 4 2007	Erec	s. speed							

DHMH 17 Rev 1/2001

Box 68760, o Division or Vital Records, P.

To the Hospital within 24 hours a To the Funeral I

State Registrar

29b. Signature and title

31. Date filed (Month, Day, Year)

JAN 2 3 2007

gistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Guy Patrick Murchy 1500 Forest Glen Rd. Silver Spring, Md. 20910

29c. License number D41624

29d. Date signed (Month, Day, Year) 1/20/07

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** SHARON YU-SHANG BOESCH-CHUA JAN 19 2007 10:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 24, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year) 1 □ M 2 🖺 F 586-55-7357 29 1977 Singapore Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or itema 23a or 28a-f show traumatic svent, the Madical Examinar in ust be notified at Maryland Saint Marys California 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23238 Surrey Way, Apt. L 20619 Singapore death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after de ital Hygiene. d other then "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management Hospitality permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic svent 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Chua Keng Hee Judy Hou Ling Chiao 19a. Informant's Name/Relationship (Type, Print) us and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Garrett Davidwayne Boesch/ 23238 Surrey Way, Apt. L, California, MD 20619 20b. Place of Disposition (Name of Jan. 20, 20a. Method of Disposition 20c. Location - City or Town, State ometropolitan place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)/ Crematory natory 2007 Alexandria, Virginia
22. Name and Address of Facility DeVol Funeral Home, 10 East 21. Signature of Funeral Service Lice see Deer Park Drive, Gaithersburg, MD 20877 terthe disease, or complications that caused the iplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death SYSTEMIC LUPUS ERYTHEMATOSUS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2X No Physician: 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1X Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? al or Attending P s after death. il Director: After After 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral E Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) un Vance 12 16746 (OR) JAN 19 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LEE VANCE, MD BETHESDA MD 20889-5600 legistrar's Signature 31. Date filed (Month, Day, Year) JAN 23 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] ] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** BROOKS Year JOSEPHINE 1220 AM 200 20 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Kris-Leigh Assisted Living Davidsonville Anne Arundel 8. Date of Birth (Month, Day, Year) May 28, 19 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Yrs. Director 236-32-2922 1921 West Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Anne Arundel Davidsonville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3913 Birdsville Road 21035 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No If Yes, Give Year or Dates: Specify: ģ Specify: white 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) clerk 8 U.S. Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg important: if Item 27 is marked other eny injury or other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Stella Rae Lilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee B. Wilson, daughter 153 Sansbury Rd., Friendship, MD 20758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) James' Parish Cem. 01/22/2007 Lothian, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licen 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be executed attending physicien and for use as the burial-transit Exam Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Completed by ATHEROSCLEROSIS 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate Division of Vital the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 24 hours e 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner plated (Check only one) within 2 To the ţ 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DO2519 MI Mulaca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWERS GIEN BURNIE, ISHER CZAIN 21061 KICHARD 31. Date filed (Month, Day, Year) 32. Registras Signature State Elegen 2007 Registrar 3

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Sarah Carolyn 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PANIASULA REGION OF 5AUSBUM Medicol Vicinico If Upder 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 T F Months Days Min. 59 419-66-8543 9/4/1947 Alabama Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. inside City Limits 1XIYes 2□No Maryland Wicomico Salisbury 10e. Street and Number 32325 Mt. Hermon Road 10f. Zip Code 21804 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Child Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A. Boyett Laura Edge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Bond/husband 32325 Mt. Hermon Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Springhill Memory Gardens 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/25/07 Hebron, MD 21. Signature of Funeral Service License Thorisway Tuneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 West leiney 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute 15 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Industry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown y to penia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy med. perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of D th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1X Natural 2 Accident

**Physician** /Medical Examiner

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra

Physician

/Medical

Examiner

Director

Funeral

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Be

Funeral

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show

1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene.

em 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

attending physician certificate has funeral director, After this

Physician/Medical

the within 2 Registrar

Box 68760. P.O. Records, Completed Vital Be Medical Certification: To 0 Division Hospital or Attending 24 hours after death.

29b. Signature and title of certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

DZ4986

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/19/07

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

560 Riverside Dr. Blos Salisbury Md. 21801 Robert Reilly MD

31. Date filed (Month, Day, Year) JAN 23 2007

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature

			State of Maryland / Department of Health and Mental Hygiene 0 7 0 3 3 6 (  State Registrer Certificate of Death Reg. No.  1. Decedent's Name (First, Middle, Last)	
	Physici /Medio		Rudolph C. Beitzel Jan, 19, 2007 9:10 P	
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  SALISBURY REHAB & NURSING CENTER SALISBURY, MD. 21804  WICOMICO	
	Funeral Director		5. Social Security Number 157-09-7577  1 M M 2 F 89 Yrs.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) (Month, Day Year) 7/23/1.917  9. Birthplace (State or Foreign Country) California	gn
	the Maryland 28a-f ahow	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
0)	death with the Maryland ms 23a or 28a-f ahow	Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?	_
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udalpholore, Maryland	1 and 2 should Health and Mer Hem 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Rudy Beitzel/son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5 Fairway West, Georgetown, DE 19947	
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Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Facility HOLLOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804	
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ó,	rate be executed by the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Due to (or as a consequence of):  Cause. (Create of in jury that initiated events resulting in death) Last  Due to (or as a consequence of):	
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Ö	lospital or in hours after uneral Dire	,	building, etc. (Specify)  City or Town, State)	_
	To the Hospital of within 24 hours af To the Funeral D completely filled in		(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)	
7	Pan 14		O. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIT,LIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804	
	Stat Registra	٠,	1. Date filed (Month, Day, Year)  32. Registrar's Signature  JAN 2 3 2007	

			For State Registrar	State of	Marylan		artment of t		Mental Hy	giene Reg. No. 2	007	03367
	Disconing		1. Decedent's Name (First, Middle, La	ast)					2. Date of De		Year	3. Time of Death
	Physici /Medi		John Depew Bowe	n			, -		Jan	18	2007	945 A W
	Examir		4a. Facility Name (If not institution, gi		•			or Location of Dea	ath		unty of Death	
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	Funeral Director			Sex 12XM 2□F	'. Age (In yrs. i 53	Yrs.	Months Days			y, Year)	9. Birthp	elace (State or Foreign etry) MD
	ט		Usual Residence of Decedent									
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	with ti	Dic	10e. Street and Number				10f. Zip Code 21842	,		10g. Citizen	of What Cour	ntry?
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<b>(0</b>	riter d	F	1 Never Married 2 Married	Armed Ford	ces? 2.5x7No	ĺ			(Specify Yes or No erto Rican, etc.)	1	Black, White,	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "netural", or items 23s or 28s -f ehow the hybrid properties of the returnant event, the Medical Exportment per profittled at 2006.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat			1 ☐ Yes 2X No	Specify:		Sp	ecity: Bla	CK
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an	ld be ental ked c	To Be	Depew John Bowen						Hudson			
ary	shound M mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Numbe	r, City or To	wn, State, Zip	Code)
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ore,	of He of He item		20a. Method of Disposition	70		lace of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Locati	on - City or To	wn, State
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Baltimore,	permit. Depertrimports any injugate.		21. Signature of Funeral Service Lice	nsee		22 T	2. Name and Addre	ess of Facility	Tuneral Ho	ome.		
	80 = 3 a		23a. Part1. Enter the disease, or conshock, or heart failure. List only	NON		1	618 West	Rd Sa	lishury	MD 21	801	Approximate Interval Between
	Physician /Medical Examiner and parial-transit	cai Examiner	disease or condition resulting in death)  Securities list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	bDue to (o	r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a consequence of as a consequence of as a consequence of as a consequence of a cons	uence of):	- CARD	i 0 -VA.	SCULAF.	DSE	ASE 1	FW YRS
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-00	ling Phys ). After this funeral di		27. Manner of Death 1 Malatural 5 ☐ Pending	28a. Date of (Month)		28b. Time of		v at	28d. Describe h			/
Bowen - 2280	uttendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	n				Yes 2 □ No				
D. Bower Se-228 Division	l or Attendefer death ofter death Director:	Certification:	4 Homicide determined	200. Place 0	f Injury - At ho g, etc. <i>(Specify</i>		eet, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	imber of Rural	Route Number,
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	, XVIII		30. Name and addr- of person who	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1111	23a) (Type	Print)	06241		01-	11-07	
7	00		DORGTHY C.	HOLZW	•	M.	D. 20-	3 JAIOUN	ST. SAI	011/4/	u. Mi	,21863
	Sta		31. Date filed (Month, Day, Year)	32. Dec	gistrar's Signat	ure		// /	- / /			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Doris Marie Burnham January 2007 1:35 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Wicomico Salisbury
Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/1/1922 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 F Hours 85 213-14-1682 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shov idical Examiner must be notified at 1 XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? within 72 hours after death with 900 Booth Street 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 2 3 Nidowed 4 Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) I Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important; If item 27 Is marked other the any injury or other traumatic content the Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Franklin Morris Theresa Delaney Brumbley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward C.P. Feeney/son 832 S. Schumaker Dr., Apt. 104, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place)
Springhill Memory
Gardens Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/26/07 Hebron, MD Signature of Funeral Service Licensee Professional Association 501Snow Hill Rd., Salisbury, MD 21804 and H. CESP Crocamon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (at as a consequence of) Examiner HNE VMON Sequentially list conditions Sequentially list condition trans, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physiclan/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the rusping after death.

within 24 hours after death.

7 To the Funeral Director: Aft

State Registrar

29c. License number 206,0515

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Easternshore Drive, Salisbury, MD Maesha Thimmarayappa, MD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only

JAN 2 4 2007

32. Registrar's Signature

				1 - For State Registrar	State of Ma	ryland / [	epartn					71111	03369
		Physici	an.	Decedent's Name (First, Middle, Last)						2. Date of De Month	aath Day	/ Year	3. Time of Death
4		/Medic			Enid Eli	zabeth				Janua	_		11:00 AM
-		Examin	ier	4a. Fecility Name (If not institution, give str.			4b.	City, Town, o	r Location of Death	1		County of Deeth	
				5. Social Security Number 6. Sex		(In yrs. last bin	thday) If	Jnder 1 Year	If Under 24 Hrs.	8. Date of Bir		NICONIO 9. Birtho	
	ш	Funeral Director			4 2⊠F			nths Days	Hours Min.	8. Date of Bir (Month, De April 10		7 New	place (State or Foreign ntry) York
		- 6		Usual Residence of Decedent									
		how		10a. State 10b. County		10c. City, Town	n or Locatio	n				1	10d. Inside City Limits
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12		within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow the Medical Exempler must be notified at	Funeral Director	11. Marital Status 12 Married 12	. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes	s, specify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, White,	
3	36	irs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		101	′es 2□No	Specify:			Specify: Bl	ack
RN	21215-0036	2 hou	ted	15. Decedent's Educa		16a.	Decedent's	Usual Occup	pation	rking	16b. Ki	ind of Business/In	dustry
W	215	Bn "n	Completed	(Specify only highest grade of Elementary/Secondary (0·12)	College (1-4or 5+	+)	life. DO N	OT use retired	during most of word)	King			
8		filed will Hygien other th	Co		3		Routi	ng					te Disposal
	pu	d oth	Be	17. Father's Name (First, Middle, Last)	_				18. Mother's Nar	me <i>(First, Middl</i> e Le Smith		Surname)	
0	<u>×</u>	should ind Men marke umatic	၉	William Hightower,		101						T 04.4. 7	0-1-1
RE	Maryland	12 sh h and 7 la m traum		19a. Informant's Name/Relationship (Type Willie Bennett/Husb					a <i>nd Number or Ru</i> n Street				
Vi		1 and Health am 27 ther tr	1	20a. Method of Disposition		20b. Place of	Disposition	(Name of		Date		ocation - City or To	
V	5	ages ant of t: If I		12 Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		-	y`or other plac	dens Jan.	26 2007	Uoh	oron, Mai	outland.
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or itema 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service Licensee	. 0	Springir		me and Addre				Maryland	-
	ä	Depar Impo any ir		Loretta K	Stoll	en	Jol	ley Mer	morial Ch	napel -	1213	_	
	B I	1		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused to	the death. Do i	not enter the	mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	-	Physician		Immediate Cause (Final disease or condition	Chron	ic Ol	25tr	uctiv	e to1	monar	u 1	Disease	Onset and Death
		/Medical		resulting in death)	Due to (or as a	consequence	of):				) '		
	В	Examiner		Sequentially list conditions, b.		ngem							
		pe #s	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chror	consequence	dne	47	sease	9			
	_	be execut icien and burial-tran	Examiner	that initiated events c. resulting in death) Last		consequence		1	75005				
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	687	ficate g phys as the		d									
	ŏ	eath certifical attending phy for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c	:. If yes, outcome o		a ∏∈oto	pic pregnancy	,		1	23d. Dale of deliv	
	B	ne death the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at t			er (specify)	у			Month	Day Year
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	Ś	res tha	b	Part II. Other significant conditions contr	SIStan	1 47 1					-		he cause of death?
	ord	v requir been si should	ted	Van congan ize	31 31an	10/11	1010	06003					Sabiy 4 Donkhown
	Sec.	e law has b	n de	Diabetes Mel U	tus, 1	Tepa-	1111	SCV	NUS,	24a. Was		24b. Were auto prior to co death?	opsy findings available impletion of cause of
	aiF	s <b>ician:</b> The lar certificate has rector, page 2		Ity pertensic	11					1 Yes	2 <b>/2</b> -No		2□ No
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	ō	Phys rrthis aral di	: To	27. Manper of Death	28a. Date of Injury (Month, Day		Time of	28c, Injur	rv at	28d. Describe		6 Other (Special of the control of t	y)
	on	Attanding Physician: The law requires that the death certificat (death). actor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	atior	1∕2€Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) I	njury N	Wor 1 □	rk? ]Yes 2∐No				
	Division of Vital Records, P.O. Box 68	Atta	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, fa	rm, street, f	actory, office		28f. Location (		d Number or Rur	al Route Number,
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		or To on on	V	Pilen	1 lan le	this	40	^	106022		-	vary 22	
		1	1	30. Name and address of person who com	pleted cause of de	ath (Item 23a)	(Type Print			3	-JUN	7 2.	,
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		Sta	ate	31. Date filed (Month, Day, Year)		r's Signature			<del></del>				
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State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State o	of Marylan								200	7	03371
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	death ms 2; r mus	nera	11. Marital Status	12. Was Dec		S. 13.				gin? (Spe	cify Yes or No-		14. Race - A	merica	n Indian,
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<u> </u>	other other vent, 1		17. Father's Name (First, Middle,	Last)							(First, Middle,	Maiden			
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	neral neral y fillec	a C	29a. Certifier 1 € Certifyir	g Physician: To the	best of my know	wledge, death	occurred:	at the tim	e, date an	d place, a	nd due to the o	ause(s)	and manner	as sta	ted.
	in 24 in 194 in	edic	(Check only 2 Medical one)	Examiner: On the b	asis of examinat ner stated.	tion and/or inv	vestigation,	, in my or	oinion, dea	th occurre	ed at the time, o	date and	place, and	due to 1	he cause(s)
i	To t Com	Σ	29b. Signature and title of certific	1/1/	. Ch		290								
			Mur 1	man	all			D 2	9453		J	anua	ry 16	, 2	UU / 
-	l		30. Name and address of person		·		,	n ·	. 7 7	- 36	00050				
	Sta	te	Alan Chanales N 31. Date filed (Month, Day, Year)	1.D. 15225 32. ₩	o Snady gistrar's Signat	ture	Kd.,	KOCK	CVILL	e, M	20850				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 January 16 Richard Be1cher 7:37a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1003 Sunny Brook Drive Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sep. 7, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1X M 2□ F 295-18-3059 83 Berlin, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 Sunny Brook Dr. 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☑ Yes 2 □ No if Yes, Give Year or Dates: WW II 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Belcher Buelah Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Catherine Belcher (Wife) 1003 Sunny Brook Dr. Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Hillcrest Jan 20 2007 Annapolis, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Faneral Service Licens at 12 Ridgely Ave Annapolis, Md 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Approximate Interval Between Onset and Death Immediate Cause (Final 140 resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 De Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner law requires that the death certificate be executed and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

ral", or Items 23a or Examiner must be

"natural",

l Hygiene. other than "

Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If item 27 Is marked other t Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, I once.

the Medical

filed within 72 hours after death

altimore, Maryland 21215-0036

Director

Funeral

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Examiner burial-trar Physician/Medical the as attending plant for use as led by the a been signed by should be detac ≥ Completed certificate has b irector, page 2 s funeral director, Be P Certification: ours after death.
neral Director: A
filled in by the fu

Division or Vital Records, P.O. Box 68760,

within 24 hours at To the Funeral C State Registrar

ō

Hospital

28c. Injury at Work? 5 ☐ Pending investigation Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza Nusairee Madison Park Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar

State

Registrar

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DHMH 17 Rev 1/2001

MD 2555 Solomons Is Rd. North Huntingtown MD 20639

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2007▶

Yazdani,

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			Registrer  1. Decedent's Name (First, Mide	dle Last)				runcai	e or L	Calli	2	. Date of Dea	eg. No.		3. Time of Death	
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ī	Director		244-62-3802	1□ M	2LXF	63	Yrs.	Months	Days	Hours !						
	and *		Usual Residence of Decedent  10a. State 10b. Count	v		10c. C	ity, Town or Lo	ocation				· <u></u>			10d Inside City Limits	
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	3a or	Funeral Director	1215 West 01d	Philad	le1ph	ia Roa	đ		2190	1		T	Init	ed Stat	· es	
	death	nera	11. Marital Status	12.1	Was Dece	dent Ever in		Was Dece			? (Specif	y Yes or No-		14. Race - Ame	nican Indian,	
စ္	after or ite		1 Never Married 2X Ma	rned	Armed For 1 ∐Yes If Yes, Give	2 💢 No		1 Tes, spe		Specify:	ruento Hid	an, etc.)				
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or iteme 23e or 28e-f ehow event, I'm Madical Exemplar manal be redified at	d by	3 Widowed 4 Divorce	d	Year or Da			103	- JAL 140	Spoony.				Specily. WILL	. Le	
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Maryland	es 1 and 2 should be of Heelth and Mental fitem 27 ie marked o r other treumatic eve	To B	Charlie Samu	el Joh	nson					Vern	na Ni	cho1sc	n			
ary	should and Men marke umatic		19a. Informant's Name/Relation	iship (Type,	Print)		19b. Maili	ng Addres	s (Street a	nd Number o	r Rural R	loute Number	City or	r Town, State, 2	Zip Code)	
	and 2 selth a n 27 is		Patty Reed / D	aughte	r		P.O.	Box	239 N	orth F	last.	Mary1	land	21901	i	
ore	of He		20a. Method of Disposition  (XBurial 2 Depmation	•			Place of Dispo cemetery, cre-	sition (Na	me of	, _	Date	•	20c. Lo	cation - City or	Town, State	
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Ba	permit. Pege Department of important: if any injury or once.		21. Signatur of Finanti Prvic	Licylism	1		2:	2. Name a	nd Address	of Facility	Crou	ich Fur	nera	1 Home		
	d0 = 8 d		23a. Part 1. Enter the disease,				13	27 So	uth M	lain St	reet	, Nort	h E	ast, Ma	2007 01:00 PM unty of Death ccil  9. Birthplace (State or Foreign Country)  8 North Carolina  10d. Inside City Limits 1 Yes XXNo of What Country?  1 States  Race - American Indian, Black, White, etc. ecity: White of Business/Industry  Home mame)  wm, State, Zip Code)  21901 on - City or Town, State  East, Maryland Home St, Maryland 21901  Approximate Interval Between Onset and Death  Date of delivery Month Day Year  contribute to the cause of death? on 3 Probably 4 Unknown  1b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No  Other (Specify)	
			shock, or heart failure. List	st only one ca	ause on ea	ch line.	un. Do not en					aspiratory arre	est,		Interval Between	
j.	Physician /Medical		disease or condition resulting in death)	a	Bre		ראונט	nu	testeu	カル						
	Examiner			4	1	or as a conse		N	1110	NC.						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. —		or as a conse	~	J	LLPC							
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Ď,	icate be executed physicien and s the burial-transit	EX	resulting in death) Last		Due to (d	or as a conse	quence of):									
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×	eath certifi attending     for use as	/Me	IF FEMALE:	23c. l	f ves. outc	ome of pregr	ancv									
ROX	death certifi e attending   ed for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live bir	th 2 Fet	al death 3	Ectopic p							,	
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c,	The law requires that tie hes been signed boage 2 should be deta	Jy P	Part II. Other significant condit	ions contribu	uting to dea	ath bul not re	sulting in the u	nderlying	ause giver	n in Part I.		23e. Did tob	oacco u	se contribute to	the cause of death?	
ğ	equire en si										_	1 🗆 Ye	es 2 5	No 3□Pr	obably 4 Unknown	
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<u> </u>	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	al Hosp	ital:				1 -			heck only on				
<u>o</u>	Phys this ral di	٠ <u>۲</u>	1 Yes 2 No		1 🗀 In		28b. Time o			4 🗀 INUISI		5 Reside			cify)	
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	spital or ours afte oers! Dire	Certification;	4 Homicide		buildin	g, etc. (Spec	ity)					City or Town	i, State)			
	ne Hospital or Attendi 124 hours after death. Ne Funerel Director: A bletely filled in by the fu		29a. Certifier 1 Certify (Check only 2 Medica	ing Physicie I Exeminer:	n: To the t	pest of my kn	owledge, deat	h occurred	at the time	e, date and p	lace, and	due to the ca	ause(s)	and manner as	stated.	
	To the Hos within 24 h To the Fur completely	Medicai	one) 29b. Signature and title of certif.		and manne	er stated.										
١	5 3 5 8		I Am cere	is la	1110			2.3	Decel	(2) >			i j	1		
,			30. Name and address of perso	n who comple	eted cause	of death (Ite	m 23a) (Tvne	Print)	UTI	003			1	1- 211	•	
	3		JUI CHIH	HSLI,	MD	22	m 23a) (Type,	pt 2	wein	st,	GI	Ore 1	Ho	1 219	121	
	Sta		31. Date filed (Month, Day, Yea	3 201	32. Re	strar's Sign	ature	board	E)							
	Registr	ar	Onit '	- 201		9 ( J. C. J. S. J. S. L. J. J. S. L. J. S. L. J. S. L. J. S. L. J. S. L. J. S. L. J. S. L. J. J. S. L. J. S. L. J. S. L. J. S. L. J. S. L. J. J. J. J. J. J. J. J. J. J. J. J. J.	100									

			1 - For State Registrar	State of Marylai	nd / Depa		Health and			0 7	03377
	Physic /Med	ical	Decedent's Name (First, Middle, La     Decena     Aa. Facility Name (If not institution, girl	Marcilla		Dali	ida		Death y 21, 2007		3. Time of Death 12:50 P M
	Exami Funera Director	40/2/2	Southern Maryland 5. Social Security Number 6.	Hospital Sex 7. Age (In yrs.	. iast birthday) 74 Yrs.	4b. City, Town, Clinton If Under 1 Year Months Days	If Under 24 Hr	S. 8. Date of E	Princ	e Georg	ge's blace (State or Foreign ntry) ippines
36	d within 72 hours after death with the Maryland Jiene. I then "naturel" or iteme 23s or 28s-f show the Madical Examiner must be notified at	y Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Prince G  10e. Street and Number  301 Round Table Dri  11. Marital Status  1 Never Married  25 Married	eorge's ]	l1	10f. Zip Code  207	Hispanic Origin? ( pan, Mexican, Pue	Spacify Yas or N	10g. Citizen of	What Cour	1 ☐ Yes XXX No  ntry?  can Indian, etc.
re, Maryland 21215-0036	be filed within stal Hygiene. Ind other than "event, the Mai	To Be Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last Pio Marcilla	Year or Dates: ducation ide completed) College (1-4or 5+)	16a. Deced (Give I	ent's Usual Occu	pation during most of we ad)		Speci 16b. Kind of I In Ho	Business/Ind	ipino dustry
Baltimore, Mary	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Itam 27 is marked eny injury or other traumatic events.	L	19a. Informant's Name/Relationship ( Susana D. Baes / De  20a. Method of Disposition 1 Burial 2 Cremation 3 De  4 Donation 5 Other (Specification)  21. Signature of Funeral Service Licey	Removal from State	301 R Place of Disposementery, crem 11feliza	ound Table  ation (Name of atory or other pla  Cemetery  Name and Addre	e Drive Ft.  Jan.  Jan.  Bass of Facility Ge	Washin to Date 25, 2007 corge P. K	on, Maryl 20c Location Philip alas Funer	and 2 - City or To	20744 wn, State
1760,	Physician /Medical Examiner but still but stil	icai Examiner	23a. Party. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PANCRI Due to (or as a conseq Due to (or as a conseq	h. Do not ente EATITI  uence of): FENSIO uence of): INSUF	r the mode of dyi		c or respiratory	Maryland arrest,	2074	5 Approximate Interval Between Onset and Death
.O. Box 68	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	Ideath 3□E	Ectopic pregnancy Other (specify)	4			te of deliver	ry Day Year
al Records, P	The law requires ite has been sign page 2 should be	Completed by Pl	Part II. Other significant conditions o	ontributing to death but not resu	ulting in the unc	derlying cause giv	ren in Part I.	1 24a. Was	Yes 2 No s an 24b. psy primed?	3 ☐ Proba	e cause of death?  ably 4 Unknown  sy findings available apletion of cause of
Division of Vital Records, P.O. Box	I or Attending Physician: The after death.  Director: After this certificate hat in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1	Hospital: 1 🖾 Inpatient 2 🗆  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hobuilding, etc. (Specify	28b. Time of Injury	28c. Injur Wor M 1	4 Li Nursing F	lome 5 Resi	one) idence 6  Oth how injury occur	red	
	To the Hospital or I within 24 hours after To the Funeral Dire completely filled in b	Medicai	29b. Signature and title of certifier	rsician: To the best of my known iner: On the basis of examinat and manner stated.	ion and/or inve	29c. Licens D48	pinion, death occu	, and due to the rred at the time,	cause(s) and madate and place, 29d. Date signed January	and due to t	the cause(s)
57.00 高 2	Sta Registr	te	30. Name and address of person who of Sisom Osia MI 31. Date filed (Month, Day Year)  JAN 23 2007		ill Roa	11 300	Mill, Mar	yland	20745		

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	larylan				leaith a Death	nd M		giene Reg. No.	00	7 (	33	78
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1	/Medio		4a. Facility Name (If not institution, gir	ve street and number	•)		4b. City	, Town, o	r Location of	Death	01		County of D	-	, , , ,	
145 	Funeral	- Se -		Sex 7. A		ation last birthday)		elph er 1 Year Days	If Under 2	4 Hrs.	8. Date of Birt	h	rince 9.	Birtholace	e (State o	r Foreign
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	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation								Inside Cit	
	Ba-f.	Director	DC			lashing									1 K Yes	2 🗌 No
	with th	Dire	10e. Street and Number				10f. Zi	p Code					en of What	Country	?	
	eath ne 234	eral	6517 13th St. 1	N.W. 12. Was Deceden	t Ever in U	S. 13. V	Was Dece		012 Ispanic Origi	in? (Spec	ofy Yes or No-		USA 4. Race - A	merican I	Indian.	
36	72 hours after death with the Maryland neturel; or Iteme 23a or 28a-f ehow Jical Examinal must be incitited at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces  1  Yes 2   If Yes, Give Year or Dates:	?		f Yes, spe		Specify:	Puerto F	cify Yes or No- Rican, etc.)			/hite, etc.		
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218	d within 72 ho piene. r then "netur ine Madical	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)				during most (				_			
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yland	e d a b	To Be	John Henry Love	,					Carr	rie E	Bigelow					
Maryland	nd 2 sh alth and 27 le m r traum		19a. Informant's Name/Relationship			6517	- 13t	h St	N.W. C. 20		Route Numbe	r, City or	Town, State	e, Zip Co	de)	
Baltimore,	ges 1 a t of Hea if Item or othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		, 0	lace of Dispo emetery, cren	sition (Na natory or	me of other plac	Θ)	Da	ate		ation - City			
ij	permit. Pages 1 Department of H Important: If Ite eny Injury or ot		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Ft	. Linc							twood		).	
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	Physician /Medical Examiner	Examiner	23a. Party. Ember the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumo Due to (or a:  b. Due to (or a:	ine. nia s a consequ s a consequ	uence of): uence of):			g, 30011 d3 01	ardiac or	respiratory an	531,		Int	oproximate ferval Betv nset and D days	ween
B.	e death certificate be executed the attending physicien end ned for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregna 2 🗆 Fetal	ncy death 3	Ectopic p	oregnancy pecify)		Ţ,		23	3d. Date of Month	delivery Day	y Y	'ear
s, P.O.	law requires that the de as been signed by the a 2 should be detached t	by Phy	Part II. Other significant conditions	contributing to death	but not resu	ılting in the ur	nderlying	cause give	en in Part I.		23e. Did to	bacco us	e contribute	to the ca	ause of de	eath?
ords	w require been sig should b		Alzheimers Deme	ntia						_	1 🗆 Y	es 2X	No 3□	Probably	y 4 □U	nknown
<u> </u>	The ate h	Completed									24a. Was a autops perform	med?	24b. Were prior to death 1 $\square$ Y	to comple	findings a etion of ca XNo	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			_	Othe			Check only or	-				
ion of	ding h. After fune	atlon: To	1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, Da		ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 EF NUIS	28	e 5 Reside			pecify)		
É	P G G	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At ho tc. (Specify	me, farm, stre	eet, factor	y, office		28	Bf. Location (Si City or Town	treet and n, State)	Number or	Rural Ro	oute Numb	ber,
	the Hospital	dical	29a. Certifier (Check only one) LCertifying Pl	nysician: To the best miner: On the basts of and manner s	of examinat	wledge, death ion and/or inv	occurred estigation	at the time, in my of	e, date and pinion, death	place, ar occurred	nd due to the c d at the time, d	ause(s) a ate and p	nd manner place, and d	as stated lue to the	d. cause(s)	
,	To th To th comp	Me	29b. Signature and little of certifier	1///				c. License		110			signed (Mo			A 2 7
) (	(6)	İ	30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print)		1526	10	1 = 5ilv	Jan	uaru	y di	x,d	00/
	<u> </u>		Thomas/Hunuli 31. Date filed (Month, Day, Year)	S. M.D.	1086	Loc	Kw	ood	Dri	ive	Silv	ers	priv	19,1	UDá	1090
1	Sta Registr		JAN 2 4 2007	Beech	A.	South	1				-		ı			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Yvonne Frances Daughtry /Medical <u>Jan 15</u> 2007 2:47 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6505 South Solomons Island Road St. Leonard Calvert Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth J(Monthy Day3 Year) 933 Birthplace (State or Foreign Country) **Funeral** Days 362-30-9648 1 □ M 34 □ F 73 Director Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Me Itcal Examiner must be notified at Director Maryland Calvert 1 ☐ Yes 2 ☐ No St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 6505 South Solomons Island Road 20685 United States 23a Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★ lo ρ Specify: Specifiwhite 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Government manager CIA marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Frances Avila Sams h and Mental F 7 Is marked otl Be Arthur Russell LeCronier ဥ 19a. Informant's Name/Relationship (Type. Print) husband James Ventress Daughtry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other tra once. P.O. Box 406 St. Leonard MD 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) Clinton Cemetery Jan20 2007 Clinton North Carolina 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** vetastatic disease or condition resulting in death) Cancer Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autonsy perform 2 No 1∐ Yes l or Attending Physician: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury ↑∐Natural 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 12 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the 29b. Signature and title of certifier 29c. License number ပ္ 29d. Date signed (Month, Day, Year) 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel Hospital Rd. Prince Frederick MD 20678

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Registras Signature

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	= .		1 - For State Registrar	State of Marylar		artment of F		-	giene 0 0	7 03380
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Mary Grace	Dickensor	n.			2. Date of De Month Januar	Day Yea	
,	Exami		4a. Facility Name (If not institution, give 14981 Potomac	River Driv			Island	ath	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Sec. 1D Usual Residence of Decedent	7. Age (In yrs.		If Under 1 Year Months Days		s. 8. Date of Birt (Month, Da eptembe	y, Year) 15,192	Birthplace (State or Foreign Country) 2 Ohio
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f show thit, the Medical Examinar mest he notified at	Director	MD 10b. County Charl.		ity, Town or Lo	sland				10d. Inside City Limits 1 ☐ Yes 2 X No
	e 23a or	rai Dir	14981 Potomac				625		10g. Citizen of What USA	Country?
9036	permit. Pages 1 and 2 should be liled within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or itsme 23a or 28a-f show any injury or other traumatic svent, the Medical Examinar must be notified at ance.	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2√ No If Yes, Give A Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I □ Yes	ispanic Origin? (i in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
21215-0	I within 72 h iene. r than "natu the Medical	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired Homemake	during most of wo ()	orking	16b. Kind of Busine	
Maryland 21215-0036	ould be filed Mental Hyg arked other attc event,	To Be C	17. Father's Name (First, Middle, Last) William Lawrence	ce Cropley		- Comomark		ame (First, Middle, Gantz		Home
	tand 2 sh Health and tsm 27 is m		19a. Informant's Name/Relationship (Ty.  Michael Walter/  20a. Method of Disposition	Son 206. F	43311	Longle	af St.		r, City or Town, State  Riding  20c. Location - City	
altimore,	permit. Pages Department of Important: If I any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Bri	nsfiel	.d-Echol	s 1/2	9/07 C	•	Hall,MD
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	o causo on bacin illio.	th. Do not ente	TT St. er the mode of dying	Mary's g, such as cardia	Ave. L ic or respiratory arr	a Plata,	MD 20646 Approximate Interval Between
8760,	physicien and physicien and physicien and physicien and sthe burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	guence of):		700(70		2/3 (700	
O. Box 6	the death certif y the attending ched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ MNo 9 □ Unknown	Bc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
Records, P	es the	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did tol	_ \	to the cause of death? Probably 4 Dunknown
		Completed						24a. Was a autops perform	v prior to	
VITAI	Physician: this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital:	ER/Outpatient	3□ DOA Othe		ath Check only on	e) ence 6 ⊟Other (Sp	
	ding After fune	ation: T	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	өсіту)
=	2 # # E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	v)	,		City or Town	,	
	To the Hospital within 24 hours a To the Funeral ( completely filled	edical	29a. Certifier (Check only one)  Cartifying Phys 2 Madical Examin	ician: To the best of my kno- er: On the basis of examinal and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my opi	e, date and place inion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To the vithin comp.	M	29b. Signature and title of certifier	11		29c. License	number	2	9d. Date signed (Mor	nth, Dey, Year)
0			30. Name and a dress of person who cor	nolated cause of death (Ita-	1 23a) (Tunn 17	D4	4436		IAN 2	3 2007
	B12	1	Ashvin J. PAT	el MD 102	PAU	Mellon	Of h	+102 W.	Aldert n.	N 20602
	Star Registra	-	31. Date filed (Month, Day, Year)  JAN 2 4 2	32. Auristrar's Signa	ture	have				3 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30, 2007 Month **Physician** Florence Amelia Deniker January 6:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Grantsville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Bill University | 9. Goodwill Mennonite Home 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Months Days Yrs. 219-56-9322 Director 91 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Accident MD Garrett Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21520 USA 2256 Rabbit Hollow Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 **X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Bach Effie Geora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Rabbit Hollow Rd., Accident, MD 21520 Roy D. Deniker/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State John's Cem. Feb. 2, 2007 Accident, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee eumou 0 P.O. Box 275, Grantsville, MD 23a. Part 1. Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help it failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cay e (Final disease or condition resulting in death) **Physician** neumon /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Live birth Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown signed by Part II\_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ peq 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an Was an autopsy performed? this certificate has 1 Yes Hospital or Attanding Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide within 24 hours after To the Funerel Dire Delli 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LXXX34 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 21536

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State

Registrar

31. Date filed (Month, Day, Year)

FEB -

32. Registrar's Signature

200

07-00786 Donald DeWitt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ertificate	of Death	and Men	R	eg. No. 200	7 0338	
Physicia edical Examir	n/	1. Decedent's Name (First, Middle,Last)  Donald Bruce DeWitt				2. Date of Dea Month January 2	th	3. Time of Death 1345 hrs	
torio		Facility Name (if not institution, give street and number)     4923 Hutton Road		4b. City, Town Oakland	, or Location o	f Death	4c. County of Dea Garrett	th	
Funeral Director		215-26-6233 1XM 2F 78	s last birthda		Year If Under Days Hours		/1000 Fore	Birthplace (State or eign Sountry) Maryland	
ie Maryland nr 28a-f show any <u>fied at once,</u>	ior	MD Garrett	ity, Town or L	ocation akland				10d Inside City Limits 1 Yes 2 X No	
the Mary  3a nr 28a- otified at	Director	10e. Street and Number 4923 Hutton Road		10f. Zip Cod	21550		0g Citizen of What Co USA	untry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No.  3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	1		No specify:	in? ( Specify Yes or No Puerto Rican, etc.)	White, etc.	erican Indian, Black,	
136 thin 72 hou se. than "natedical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	duri	ng most of working	life DO NOT u		Auto Rej	ŕ	
1215-00 I be filed wir ental Hygien arked other vent, the M	Be	17. Father's Name (First, Middle, Last)  Troy Bruce DeWitt	_ <b>.</b>	-	С	s Name (First, Middle, Mora Ma	e Upho		
MD 2:	ဍ	19a Informant's Name/Relationship (Type, Print) Robin R. Niner/ Daughter	604	King's E	Run Roa	d, Oakland	ber, City or Town, Stat , Maryland	21550	
imore, Pages I an nent of Hea ant: If ite		1 X Burial 2 Cremation 3 Removal from State	crematory	sposition (Name of or other place)  Co. Mem.	-	Date 2/1/07	20c. Location - City o	·	
Bait permit. Departe Import		21. Signature of Funeral Service Licensee		Stewart 1	Funeral	Home O	akland, MD		
Physician / Medical Stammer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Purple of the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Purple of the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Purple of the disease of complication of the disease or condition resulting in death.  Due to (or as a consequence of):  Sequentially list conditions,						Approximate Interval Between Onset and Death			
<i>.</i>	اير	Sequentially list conditions, b							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last							
760, icate be executed physician and the burial - transit	/Medical E	d. UNPENDED AMENDED							
OX 68 eath certif	Physician/Med	PF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of properties of the past 12 months?  1 Unknown	2	Fetal death Other (Specify)	3 Ectopic	pregnancy	23d. Date of deliver Month	ry Day Year	
ires that the de signed by the detached i	<u>آھ</u>	Part II. Other significant conditions contributing to death but no	ot resulting in t	the underlying caus	se given in Par		bacco use contribute to	the cause of death?	
Division of Vital Records, Propriet and retending Physician: The law requires the safer death at Director: After this certificate has been signed in by the funeral director, page 2 should be d	Completed					24a. Was a autopi perfor	sy prior to med? death?		
Vital hysician: this certi	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital 1 Inpatient 2	ER/Outpar		Other	Nursing Home 5	Residence 6 🗸 Othe	er: Scene	
Sion of Attending Physical death ctor: After if y the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a Date of Injury FOUND: Day, Year) Jan 28, 2007	28b. Time FOUND 1330 hrs	1	njury at Work? Yes 2 ✔ I	No Exposure to	ow injury occurred cold Environmen	t	
Division  Hospital or Attend 24 hours after death Funeral Directors stely filled in by the		Suicide Could not be	4 Homicide determined (Specify) Farm/Ranch or Town, State) 4923 Hutton Road, Oakland, MD						
To the Ho within 24 h To the Fu	edical	one) 2 Medical Examiner:On the basis of examination and manner stated	edge, death o n and/or inves	ccurred at the time tigation, in my opin	, date and plac nion, death occi	e, and due to the cause urred at the time, date a	e(s) and manner as sta and place, and due to the	ted he cause(s)	
	2	29b. Signature and tille of Certifier			ense number C.M.E.		January 29, 200		
	8	30. Name and address of person who completed cause of death (Ite Susan Hogan MD. Assistant Medical Examination	er 111 F	Penn Street, B	altimore, M	D 21201			
Sta Registi	130	31. Date filed (Month, Day, Year) FEB - 1 2007	ature	and s					
DHMH 17 Rev 1/20	01	**	ORIGI	NAL					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H		lental Hy	giene	7 03383	3
	Dhusia		1. Decedent's Name (First, Middle, Li	ist)				2. Date of De	aath	3. Time of Death	1
12	Physic /Medi Exami	cal	Margaret Susan I			4b. City, Town, or	Location of Death	Month Jan	Day 17 200 4c. County of		M
7	_ Adding		Crofton Convaleso	ent Center		Crofton					
	Funeral	1	5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	Anne A	Birthplace (State or Foreit Country)	ign
3	Director	1	220-56-0432	1 □ M 2 <b>X</b> F	74 Yrs.	Months Days	Hours Min.	Jun 11		Luton, Englan	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L						
	ehow	5				ocation				10d. Inside City Limi	
	the Ma 28a-f	ect	MD Anne Ar	undel	Odenton					1 ☐ Yes 2 <b>次</b> N	40
	<b>≘</b> ₽ ■	<b>Funeral Director</b>				10f. Zip Code			10g. Citizen of W	nat Country?	
	eath w	era	516 Camelot Court	12. Was Decedent	Every in U.S. Tab	21113			USA		
	iteme	Ę.	1 ☐ Never Married 2 ☐ Married	Armed Forces?	2001111 0.5.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto I	Rican, etc.)	14. Hace Black	- American Indian, , White, etc.	
336	urs att	by	3 ☐ Widowed 4 📆 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣No	Specify:		Specify:	White	
21215-0036	"neturel", or ite	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion		16b. Kind of Bus	iness/Industry	
218	within 7 ene. then "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of work done do DO NOT use retired)	uring most of workii	ng		wood maddily	
21	d wit	E O	12	College (1940)	Supp	ly Clerk			Federa1	Government	
P	should be filed vand Mental Hygie marked other furnatic event, in	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name	(First, Middle,	Maiden Sumame	)	
/lai	uld b Venta	10	Arthur Mair				Rhoda Wa	11er			
Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental the Men	4	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street a			er, City or Town, S	tate, Zip Code)	
	os 1 and 2 of Health itam 27		Nita Lamneck		9434	Doral Dri	ve Pitts	burgh.	PA 15237	Fig. 1	
ore	of He of He fitan		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	D	ate		City or Town, State	
Ĕ	Pagenent in the sury o	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State by)	Metro Cr			2 2007	Baltimor	·A MD	
Baltimore,	permit. Pages Department of Important: If i eny injury or one		21. Signature of Euneral Service Lice	1599 / /		. Name and Address	of Facility Har	desty F	Juneral H	omo P A	_
Ω	89 2 2 8		Date 1	M	1:	2 Ridgely	Ave. Anna	apolis.	MD 2140	ome, r.A.	
2.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not ent					Approximate	
	Physician	0 0	Immediate Cause (Final disease or condition	House	- 1 1/2	11 9	H	C	0.000000	Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence of);	roy on	coen c	arun	ema		_
	Examiner		Production of the Control of the Con								
	7 =	ne.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					_	
	cuted nd ransi	Examine	triat iritiated events	C							
0	e exe ian a urial-1	Ä	resulting in death) Last	Due to (or as a	a consequence of):						
8760,	The law requires that the death certificate be executed the has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	dicai		_ d							
39	ndifica ng pl	Med	IF FEMALE:								
Вох	death certifica ettending ph for use as th	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy			23d. Date	,	
). E	e dea he et ed fo	sici	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	4 Pregnant at 9 Unknown		Other (specify)			Monti	n Day Year	
P.0	at the de f by the stached	h.	9 ☐ Unknown								
Ś	es tha igned be det	by	Part II. Dther significant conditions of	ontributing to death bu	it not resulting in the ui	iderlying cause given	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	
bro	w requir been si should I	ted					··	1 🗆 Y	es 2□No 3	Probably 4 Niknow	n
ec.	law r as be 2 sh	Completed						24a. Was		ere autopsy findings available	le
H	: The law cate has page 2 s	Ю						autop perfor	med? dea	or to completion of cause of ath?	
ita	ician: certitic rector,	Be (	25. Was case referred to medical examiner?				26. Place of Death			Yes 21 No	
of Vital Records,	d is	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	Othor			ence 6 Other	(Specify)	
	ding Ph h. After th tuneral		27. Manner of Death  1 SNatural 5 ☐ Pending	28a. Date of Injun (Month, Day	y 28b. Time of Injury	28c. Injury a Work?			ow injury occurred		
Division	Attending r death. ector: After by the tune	Certification:	2 Accident investigation	1	. sur,		s 2 □No				
<u>.</u>		tific	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, stre	eet, factory, office	28	8f. Location (S City or Tow	treet and Number	or Rural Route Number,	
	tal or rs afte al Dir	Cer			. (5,255.),			Oily or You	n, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely tilled in	edical	29a. Certifier Certifying Ph	ysicien: To the best of	f my knowledge, digath examination and/or inv	ontimed at the twis-	, data and place, ar	nd due to the c	ausa(s) and mann	er as stated.	
	To the P	ledi		and manner stat	led.	estigation, in my opir	non, death occurred	d at the time, c	late and place, and	I due to the cause(s)	
	S T T T T T T T T T T T T T T T T T T T	Σ	29b. Signature and tule of certifier			29c. License r		ž	9d. Date signed (	Month, Day, Year)	
,	n		<u> </u>			1389	98		1/18/0	/	
,	V		30. Name and address of per who	completed cause of de	ath (Item 23a) (Type, I	Print)		01	1	AS CONTRACTOR	
	`		Duticet sixul	Sellen	X08 (10	un Highen	14 5W	Olen	Burne	2 MD 24001	
-0.5	Sta		31. Date(filed (Mohth, Day, Year)	32. 8 gistra	r's Signature	P ~V					
-	Registr	ar	JAM T. a	CUU/	a so so						

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Dep  1 - State Registrar Ce	artment of Health and Nertificate of Death	Mental Hygie Reg.	
	36		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		David Wayne Dierdorf			17, 2007 6:30 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Tuneral Director  1199 Green Holly Drive  Annapolis  Anne Arundel  Funeral Director  5. Social Security Number 6. Sex 12 M 2 F 60 Yrs.  6. Sex 12 M 2 F 60 Yrs.  6. Sex 12 M 2 F 60 Yrs.  6. Sex 12 M 2 F 60 Yrs.  6. Sex 15 M 2 F 60 Yrs.  6. Sex 16 Months Days Hours Min. Days Hours Min. Dec. 30, 1946 IN  9. Birthplace (State or Foreign Months) Dec. 30, 1946 IN					
			1⊠M 2□F Vrs		(Month, Day, Ye	9. Birthplace (State or Foreign Country)
	n to the		312-48-1076		Dec. 30,	1946 IN
	yland Jow at			ocation	-	10d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel	Annapolis		1 ☐ Yes 2X No
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	ath wi	ral	1199 Green Holly Drive	21409		USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	72 hou natura lical E	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation	king 16t	b. Kind of Business/Industry
2	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	Namy	Nalaan Dafadaaadd
2	led w lygier her th	ပ္ပ	2	Steamfitter	an (Final Beindele Beni	Nelson Refrigerati
Maryland	t be find th	Be (	17. Father's Name (First, Middle, Last)  Leroy, Wayne, Diordorf			
2	should ind Me mark matic	오				
Σ	nd 2 s ulth ar 27 is r trau			•		
ē,	s 1 al of Hea item		20a. Method of Disposition 20b. Place of Disposition	osition (Name of	Date 20d	
altimore,	Page nent c int: If			Memorial Jar	n. 23, V	irginia Beach, VA
Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Licensee			na Park Funeral Home na Park, MD 21146
			23a, Part1. Enter the disease, or complications that caused the death. Do not er	Tayne Dierdorf  The Relationship (Type. Print)  Tarie Dierdorf/Wife  The Dierdorf/Wife  T		
	Physician		Immediate Cause (Final	athu	an. 23, Virginia Beach, VA  P.A. Severna Park Funeral Ho Hwy, Severna Park, MD 21146  Jiac or respiratory arrest, Approximate Interval Betwee Onset and Deat	
jî.	/Medical		resulting in death)  Due to (or as a consequence of):	1/1/9		15 years
п	Examiner		Sequentially list conditions by Coverage anti-	iral disease		
	Po its	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	0		
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
58760,	be e) lician buria	al E	But to (or as a sonsequented sty).			
587	ficate phys s the	edical	d			
XO	death certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
Records, P.O. Box	deat	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year
P. O.	uires that the de signed by the a Id be detached f	hy	9 U Onknown			
Ś	res th signed be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?  2 ☑ No 3 ☐ Probably 4 ☐ Unknown
0	w require been sign should b	sted			T Tes	2 No 3 Probably 4 Officiown
ဒ္ဓင	e law has b	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
a	Physician: The lavithis certificate has all director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 2 and director, page 3 and director, d				performed 1∐ Yes 2 🗓	1? death? No 1 ☐ Yes 2 ☐ No
Vita	siciar certif recto	Be	25. Was case referred to medical exampler?  1 ☑ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	th (Check only one)	
ō	Physraf di	. To	27. Manner of Death 28a. Date of Injury 28b. Time	THE SELECTION ALL NURSING H	ome 5 Residence 28d. Describe how i	e 6 Other (Specify)
on	nding th. :: Afte e fune	tio	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		
Division or	or Atter after dea Director in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or i and manner stated	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the caus	e(s) and manner as stated. and place, and due to the cause(s)
	o the ithin 2 o the omple	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Dav. Year)
)	TWI		▶ Bigitte & Miller MD	D50152	Ð.	Date signed (Month, Day, Year) hhhay 18,2007 Annopolis MD 2140,
r	7+1		30. Name and address of person who completed cause of death (Item 23a) (Type River Ha E Miller MD 2003 Me	Print) Parkway S	nite 100	Annopolis MD 2140,
	⊚ Sta		31. Date filed (Month, Day, Year)  32. P gistrar's Signature			1
	Registr		JAN 1 8 2007	Process of		
DΗ	MH 17 Rev 1/2	001				

			1 es For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	rtment of H	lealth and N Death		giene Reg. No.	0.7	033	385	
	Physic /Med		1. Decedent's Name (First, Middle, Last) Gladys P. Ennis		2. Date of Death Month Day Year 3. Time of D								
1	Exam		4a. Fecility Name (If not institution, give stre Calvert Memorial Ho 5. Social Security Number 6. Sex	(act highdou)	4b. City, Town, or Prince F			4c. Count	y of Death Vert				
	Funera Director		087-24-9481 1□ M Usuet Residence of Decedent	Sex 7. Age (In yrs. last to 1 M 2 1 T T T T T T T T T T T T T T T T T T		Months Days	Hours Min.	8. Date of Bir (Month, Da Jan. 1	5, 1932	year) 9. Birthol Coun 1932 New		or Foreign	
	ith the Marylan or 28a-f show	irector	Maryland Charles  10e. Street and Number						10g. Citizen of		10d. Inside City Limits 1 ☐ Yes 2X No		
9800	within 72 hours after death with the Maryland ene. than 'natural, or items 23a or 28a-f show the Medical Examinar must be notified at	d by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	lf	2060 Pas Decedent of His Yes, specify Cubar  Yes 2 No		ecify Yes or No Rican, etc.)	US - 14. Rac	ce - Americ	can Indian,		
Maryland 21215-0036	filed Hygir other	Be Completed by	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	on ompleted) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done di O NOT use retired) Memaker	uring most of work			)wn Ho			
	nd 2 should lith and Mer 27 is marke r traumatic	Tol	Leo Wirta  19a. Informant's Name/Relationship (Type, Dr. Eileen Ennis - D			Address (Street at Poplar H	nd Number or Rura		r, City or Town,		Code)		
Baltimore,	2 9 5 5 V		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Livensee	oval from State F1	Place of Disposi cometery, crema Orida N	tion (Name of Nory or other place ational (	Cem. 1-26	-07	20c. Location - Bushne l	City or To	lorida		
Ba	permit. Departm importation any injui	1 10	Huntt Funeral Home Waldorf, MD 20601										
	Physician and street personned street be executed by Medical street stre	dical Examiner	tmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence to	uence of):  SSTRUC  uence of):						Interval Bety Onset and I  / DA  / F 4	ween Death	
Box 6	death certi e ettending d for use a	Physician/Me	in the past 12 months?	f yes, outcome of pregna I□Live birth 2□Fetal I□Pregnant at time of de I□Unknown	death 3 E	ctopic pregnancy other (specify)			23d. Date Mor	e of detiver		'ear	
Records, P.	law requires that the as been signed by th 2 should be detache	ρ	Part It. Dther significent conditions contribu	in Part I.			co use contribute to the cause of death?						
<u> </u>	The ete h page	e Completed	25. Was case referred to medical						1	Vere autops rior to comp eath? Yes 2	sy tindings a pletion of ca D No	vailable use of	
6	tending Physication: After this the funeral directions.	ertification; To B	examiner?  1 Yes 2 No Hospi  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Subjects 6 Could not be	1 Inpatient 2	28b. Time of Injury	3 DOA Other:  28c. tnjury a Work?  M 1 Ye.	4 Nursing Hom	e 5 ☐ Reside	Check only one)  5 □ Residence 6 □Other (Specify)  d. Describe how injury occurred				
_	- 2	OF	4 Homicide determined 28 29a. Certifier 1 Sertifying Physician		Bt. Location (Str City or Town	. State)			Θ/,				
	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	Medical		On the basis of examination manner stated.	ion and/or inves	29c. License n	ion, death occurre	d at the time, da	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)				
1	RT		30. Name and address of person who comple						AN. 20		007		
	Sta Registra		John A. Weigel, MD, 31. Date filed (Month, Day, Year)  JAN 2 4 200	32. Refistrar's Signatu	ure		ince Fre	derick,	MD 206	78			

			1 - For State Registrar	State of	Marylar		artment of <i>rtificate o</i>				giene Reg. No.	07	03386
	1. Decedent's Name (First, Middle, Last)  NORMA  JEAN				-	FIKE			2. Date of De Month 01	nth Day Year			
7	/Medi Examir		4a. Facility Name (If not institution, g	4b. City, Town	, or Location	n of Death	OI	29 2007 1425 M 4c. County of Death					
			WMHS-BRADD	RADDOCK CAMPUS				RLAND			ALLE		
. 1970 1970	Funeral Director		232-60-8284	Sex 1 ☐ M 2 X F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birt (Month, Da June 20	y, Year)	Cot	nplace (State or Foreign untry) VSET, WV
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh ified a	io	WV Mine:	cal		Key	ser						1 □Yes 2 X No
	ith the or 28	Director	10e. Street and Number				10f. Zip Code	)			10g. Citizen of V	Vhat Cou	untry?
	ath w s 23a nust b		Rt. 5, Box 38					6726			US	A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	ces? 2∏No e		Was Decedento If Yes, specify Co 1 ☐ Yes 2 🎇 N			ify Yes or No- lican, etc.)	- 14. Rac Blac Specify	k, White	
9	72 hou natura ical E	ted	15. Decedent's	 Education		16a. Dece	dent's Usual Occ	upation			16b. Kind of Bu		hite ndustry
21215-0036	ithin 7 ne. nan "r	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work don DO NOT use reti						,
	iled w Hygier her th		12	A)		Certi	fied Nur				Nursi		lome
Maryland	d be fi	) Be	17. Father's Name (First, Middle, La.								Maiden Surnan	ne)	
ary	shouling Me	1º	Carl E. Westfal 19a. Informant's Name/Relationship			19b. Mailir	ng Address (Stree			A. Mye	ers er, City or Town,	State 7	in Cada)
	and 2 valth a 27 is		_Brenda F. Simpso	n/Daught	er						ester, V		. ,
Baltimore,	of He of He of item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3		20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other p	lace)	Da	te	20c. Location -		
Ĭ.	Pag tment tant; I		4 □ Donation 5 □ Other (Spec	ify)			rland C			$\frac{2}{007}$	Cumber	land,	, MD
Bal	permit Depar Impor any In		21. Signature of Funeral Service Lice	Sull	t	22	. Name and Add		Smi		eral Ho		- 1115-1
1			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
N.	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a. GLIOBASTOMA MULT FORMS  Onset and D									Onset and Death	
	Examiner		<b>1</b>	Due to (d	r as a conseq	uence of):							,000
	- Andrews	er	Sequentially list conditions, if any, leading to immediate	uėnos ul).	_				_				
/	ficate be executed physician and sthe burial-transit	Examiner	fi any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
ő	e exe ian ar urial-t	EX	resulting in death) Last	Due to (a	r as a conseq	uence of):				-			
8760,	cate be executed physician and the burial-transit	dical		d									
9	certific ding p	/Me	iF FEMALE:	23c. If yes, outo	ome of pregna	ancy							1177-11-11
.O. Box	The law requires that the death certifite has been signed by the attending sage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐Live bir	th 2□Feta nt at time of d	I death 3	Ectopic pregnan Other (specify)	cy			23d. Date Mor		ery Day Year
S,	ss that gned b	by Pi	Part II. Other significant conditions	contributing to dea	ith but not resi	ulting in the un	derlying cause g	iven in Part	t.	23e. Did to	bacco use contr	ibute to t	he cause of death?
ord	require	ted								1 □ Y	es 2 No	3 ☐ Prot	bably 4 ☐Unknown
Vital Records,	: The law cate has be page 2 sh	Completed								24a. Was a autops perform	sv l n	rior to co eath?	opsy findings available impletion of cause of
<b>=</b>	slcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: V.			lo	hor:		Check only on			
ō	y Physer this eral di	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of	3 DOA	4 LI NI			ence 6 Othe		(y)
<u>0</u>	ath. rr: Afte	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	, Day Year)	Injury	28c. Inju Wo M 1	ork? ]Yes 2∐		a. Describe ne	ow injury occurre	eu.	
Division or	al or Atte s after dez al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route N City or Town, State)								al Route Number,		
		Medical (	29a. Certifier (Check only one)  1 X Certifying P 2 Medicai Exa	hysician: To the bas miner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred at the estigation, in my	ime, date a opinion, de	nd place, an ath occurred	d due to the call at the time, d	ause(s) and mai date and place, a	ner as s	stated. to the cause(s)
	To t	Σ	29b. Signature and title of certifier		7/		29c. Licen	se number	- 1		9d. Date signed		
•				0	V		Da	33			JAN	29	,2007
	10		30. Name and address of person who	an m.	D.	625		Aver	rue.				10 21502
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 6 200		gistrar's Signa	ture							

	_1	For State Registrar	State of Mary		artment of I rtificate of		Re	g. No: UU/	0 3 3 8		
Physiciar /Medica Examine	n il	Decedent's Name (First, Middle, Li FRANK     Facility Name (If not institution, gi	A. FUQUA		4b. City, Town,		2. Date of Death Month JANUARY	Day Year 18 2007 4c. County of Dea	10:10 P		
Funeral Director				yrs. last birthday) Yrs.	IAUREI If Under 1 Year Months Days	If Under 24 H	in. (Month, Day,	Year) C	thplace (State or Fore ountry) T VIRGINIA		
Ba-f ehow		MD 10b. County PRINCE			10d. Inside City Lim 1 X Yes 2 ☐ f						
be filed within 72 hours after death with the Maryland stal Hygiene.  ad other then "neturel", or iteme 23e or 28e-f ehow event, the Medical Examinar must be notified at	rai Di	10e. Street and Number  10658 JOYCETON D  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	RIVE  12. Was Decedent Ever Armed Forces?  1 TYes 2 No If Yes, Give Year or Dates:		10f. Zip Code  20774  Was Decedent of If Yes, specify Cub  1 □ Yes 2 ☒ No	an, Mexican, Pu	(Specify Yes or No-	g. Citizen of What C U.S.A.  14. Race - Am. Black, Whi Specify:	erican Indian,		
og within 72 hou giene. er then "neture the Medical E.	Completed	15. Decedent's Elementary/Secondary (0·12)	iducation ade completed) College (1-4or 5+) 2+	(Give	dent's Usual Occu kind of work done DO NOT use retire TODIAN	during most of v	working	6b. Kind of Business			
marked other matic event, ii	lo Be	17. Father's Name (First, Middle, Las WILLIAM FUC	UA	104 14	na Addina (C)	EMMA	Name (First, Middle, M YENN  Rural Route Number,		Zio Codel		
Department of Health and Mer importent: If Item 27 ie marke eny Injury or other traumatic once.				19a. Informant's Name/Relationship  ANGELA FUQUA/D  20a. Method of Disposition  1 🛎 Burial 2 Cremation 3  4 Donation 5 Other (Spec	AUGHTER    2   Removal from State   fty)	1065  Ob. Place of Disporcemetery, cree  HARMONY	8 JOYCETO sition (Name of matory or other plate) CEMETERY 2. Name and Address	ON DRIVE	UPPER MAR	LBORO, MAR OC. Location - City of LANDOVER, M INS FUNERA	YLAND 207 Town, State IARYLAND IL HOME
sicie a bui		23a. Parti. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Saluential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a co	nsequence of).					Songet and Death		
e attending phod for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnand ⊒ Other (specify) _	y .		23d. Date of de Month	olivery Day Year		
e pe q	2	Company of the significant continuous community to deal to the resulting in the discovery dates given in the significant continuous community to deal to the resulting in the discovery dates.							s 2 No 3 Probably 4 Dunkni		
	Completed	Hyper7	Ens 1011					ed? death?	utopsy findings avail completion of cause s 2 No		
After this funeral dir	ation; lo be	25. Was case referred to medical examiner?  1   Yes   2   No  27. Manner of Death  t   Matural   5   Pending   2   Accident investigati		Residence 6 Other (Specify) scribe how injury occurred							
within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	al Certification;	3 Suicide 4 Homicide  28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - Af home, farm, street, factory, office City or Town, State)  28f. Location (Street and Number or Rural Route Number of Rural Route									
within £4 hours a To the Funaral I comple ely filled	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	miner: On the basis of exe and manner stated.	imination and/or in	vestigation, in my 29c. Licen	opinion, death o	ccurred at the time, da	te and place, and du d. Date signed (Mon	e to the cause(s)		
4 State	е	30. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death	(Item 23a) (Type, Signatule	Print)	h Rd	Ellico	tteits	/, MD Z		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Kennel **Physician** 1635 17 2007 Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MonTromer 567 Chester Town Jan hersburg 6. Sex 1**X** M 2□ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb 23, 1 5. Social Security Number 7. Age (In yrs. last birthday, rthplace (State or Foreign **Funeral** Months Days Hours Yrs. 1953 Missouri 53 Director 514-46 -7852 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and the than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at MD Montgomery Gaithersburg ¥ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 United States 567 Chestertown Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. White other than "natural", or iten vent, the Medical Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Residential Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Sales Real Estate 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Klaus Frank Eva Schoenberger ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 272 South Garfield Street Denver CO 80209 Sylvia Atencio - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Important: if its any injury or o once, 1 DBurial 2 □ Cremation 3 DR Removal from State Rose Hill Cemetery 1/22/07 Kansas City, MO 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral
1091 Rockville Pike 21. Signature Finanti Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 01:00 /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 1□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy perform 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Other: 2 No ို within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 
Natural happing-selfing (630 M 1 Yes 2 No 172007 2 Accident Jan 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) oo n (Street and Number or Rural Route Number, City or Town, State) 567 Cherter Tow determined Gaithery burg Lome 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and anner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) D00428 2101 8 cc 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ca1

State Registrar UPT

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Downs 4,33 PM /Medical Fields 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death. lennsum CONTE REGIONA Homico SAUBBUM 5. Social Security Number 6. Sex If Under 1 Year | Wunder 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Month Hours Director <u>217-10-2137</u> 90 8-4-1916 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City. Town or Location "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits Director 1X☐Yes 2 ☐ No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Clark Street 21804 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: White 3 Nidowed 4 Divorced Year or Dates permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Shirt Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ira Downs ပ Annie Mae Carev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Banks - sister 323 Dykes Road, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Springhill Memory Gds 1-25-07 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Lie 705 E. Main Street, Salisbury, MD 21804 23a. Page. Enter the disease, or companion, shock, or heart failure. List on pications that caused the death. one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Physician/Medical be detached for use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 4 Pregnant at time of death Day Year Division or Vital Records, P.O. 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: P 1 ☐ Yes 1 Inpatient After this 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Acoident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title of certifier an

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

			<b>1-</b> For State of Maryland / Department of House State of Maryland / Department / Depa	
	Physici	an	1. Decedent's Name (First, Middle, Last)  Charles F. Fleming	2. Date of Death Month Day Year  1.0.102 M
	°/Medio Examir			or Location of Death 4c. County of Death
100	uneral irector	di Sa	5. Social Security Number 218–16–6838 6. Sex 1 M 2 F 82 1 M Onths Days	
Maryland	f show ied at	lor	Usual Residence of Decedent  10a. State	10d. Inside City Limits 1 <b>X</b> Yes 2 □ No
h with the l	:3a or 28a- st be notif	Dire	Maryland   Wicomico   Fruitland   10e. Street and Number   102 W. Cedar Lane   2182	10g. Citizen of What Country? USA
<b>5-0036</b> 72 hours after death with the Maryland	r, or items 2	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 Married  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No  1 □ Yes 2 No	dispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: white
Maryland 21215-0036 nd 2 should be filed within 72 hours af ith and Mental Hydiene.	han "natura e Medicai E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Farmer	pation during most of working d)  Agriculture
land 21	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Col	17. Father's Name (First, Middle, Last) Charles F. Fleming Sr.	18. Mother's Name (First, Middle, Maiden Surname) Bertha L. Watson
, Mary and 2 shou		<b>P</b>	19a. Informant's Name/Relationship (Type. Print) Virginia Fleming/wife  19b. Mailing Address (Street 102 W. Cedar	and Number or Rural Route Number, City or Town, State, Zip Code) Lane, Fruitland, MD 21826
Baltimore, permit. Pages 1 ar Department of Hea	tant: If item jury or oth		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other pla	1/27/07 Salisbury, MD
Balt permit Depart	Impor any in once.		70,000	Funeral Home Professional Association Hill Rd., Salisbury, MD 21804
/M Exa	physician and edical eminer transit	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Initerval Between Onset and Death
. Box 6	attending for use as	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery  Month Day Year
rds, P.O	s been signed by the a should be detached to	ρχ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ren in Part I. 23e. Did tobacco use contribute to the cause of death?  1 □ Yes No 3 □ Probably 4 □ Unknown
_ =	8 0	Completed		24a. Was an autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
ır Vita nysician:	nis certificate I director, pag	To Be	25. Was case referred to medical examiner? 1   Yes   Y	26. Place of Death (Check only one)  er: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \)
Division or Attending ther death.	i Pire	Certification:	27. Manner of Death  1 Drivatural 2 Accident 3 Suicide 4 Homicide  28. Date of Injury (Month, Day Year)  28b. Time of Injury M 1  28c. Injury Wor  28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 28c. Injury 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office	y at k? Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hours a	<b>he Funera</b> pletely fille	Medical C	29a. Certifier (Check only one)  1/ Certifying Physician: To the best of my knowledge, death occurred at the tile 2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	me, date and place, and due to the cause(s) and manner as stated.  ppinion, death occurred at the time, date and place, and due to the cause(s)
To the	To the complet	Σ	29b. Signature and title of certifier  Sauce  29c. Licens	e number 29d. Date signed (Month, Day, Year)
5	g		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COA	STAL HOUSE AT THE LAKE
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 2 4 2007  32. Registrar's Signature	

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2007

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert DuVal Gardner ሻንሽ6/20бን 4:20 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood Nursing Home Frederick Frederick 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | Days | 1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 MM 2 □ F 283-18-1909 84 Yrs. Iowa Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7801 Willow Road 21701 U. S. A. 12. Was Decedent Ever in U.S.
Armed Forces?
14 Yes 2 No Army
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No White 3 Widowed 4 □ Divorced Specify: WW 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) F B I Agent U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Gardner Kathryn DuVal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Fitzgerald - Dgt. 3214 Jones Road, Woodbine, Maryland 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Memoval from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 1/22/2007 Falls Church, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc.
1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition resulting in death) ca15 Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Day 1 ☐ Yes 2 ☐ No 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to compfetion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other 
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Other 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 4 Homicide

Examiner Know-to physicianas: Robert Conding P.O. Box 68760, Division of Vital Records, death. after

neral Director: After this certific filled in by the funeral director, Hoapital or Attending To the Hospital within 24 hours a To the Funeral C

Completed by Physician/Medical Exami Be ၉ Certification:

**Physician** 

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**Examiner** 

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12 should be filed within 7 n and Mental Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other then y Injury or other traumatic event, Ingone.

Physician /Medical

death with the Manyland

29a. Certifier Medicai (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner etales. 29c. License number 29d. Date signed (Month, Dey, Year) MDD16428

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Casper Cline 31. Date filed (Month, Day, Year)

29b. Signature and trie of certifier

2 3 2007

300 West 9th st. Frederick, Md. 21701 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Peggy Stella Grimes January 18, 2007 4:00 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1451 Solomons Rutter Road St. Leonard Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sountry)

Sept. 20, 1921 England 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 225-06-8415 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1451 Solomons Rutter Road 20685 United Kingdom Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed ★☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Medical Office Manager Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Anthony Houchin Mabel Ruth Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penelope Williams (Daughter) 1451 Solomons Rutter Road, St. Leonard, MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/19/07 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brain veeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2**X** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After t 28d. Describe how injury occurred Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

Division or Vital Records, P.O. Box 68760,

within 24 hours are
To the Funeral Dir certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDDUO 5906 1 Janvary PATEL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (I) Rd Svite Prince rick 20678

Registrar

31. Date filed (Month, Day, Year) 32. Registrans Signature 2007▶ 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 03394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2007 0834 M Greene JANUARY 20 Maurice LWOOD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner albot he Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ▼M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 50 215-62-0553 Director July 22, 1956 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. 17 ie marked other then "natural", or items 23a or 28a-f ahow treumatic event, the Medical Exactinat must be motified at 1 Yes 2 No Talbot Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

1. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 No If Yes, Give Year or Dates: 21601 by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No Specify Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elwood Dorothy Elizabeth Greene Pinder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2:
Department of Heelth ar
importent: If item 27 ie
any injury or other treu 29260 Murray's Lane Trappe Maryland 21623
ace of Disposition (Name of Date 20. Location - City or Town, State Hubert Darnell Greene Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/07 trappe, Maryland aradise Cometery! 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washingtonst, Cambridge, 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dilated **Physician** Cardio myonathy /Medical Due to (or as a consequence of): Examiner CMNH USEMU Due to for as an equent of) 5 squantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical ocaine IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s certificete 2 No 1 ☐ Yes 2 ☐ No 1 Yes ivision of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 this 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t 🗠 Cartifying Physician: To the best of my knowledge, death oppured at the time, date and olane, and due to the ceuse(s) and overcer as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ø059762 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201100 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

07-00550 John Goggins

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Deat Month Day January 20, 2007 Goggins John Lawrence 1300 hrs **Medical Examiner** c. County of Death 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Pittsville Wicomico 7155 Friendship Road 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Couldassachusetts Director 031-54-7532 45  $_{1}[\mathbf{X}]_{\mathsf{M}}$ 01/01/1962 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a. State 10b. County Maryland Wicomico Pittsville Yes 2 X No 28a-f show or items 23a or 28a-f sho must be notified at once. death with the Maryland 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 7155 Friendship Road 21850 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funera Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married 2 Married 2 X No Yes white Pages I and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene, and: If item 27 is marked other than "natural", or ant: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner. 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify. Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Painting Contractor Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Marilyn Gotell James Goggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ٩ 233 Mildale Dr., Salisbury, MD 21804 Michael J. Goggins/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit Page
Department of
Important:
injury or oth 1/24/07 Salisbury Crematory Salisbury, MD Donation 5 Other Specify. Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of CFSP Dompson 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Intraoral Shotgun Wound Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) pur Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown ached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical director Be Other<sub>4</sub> examiner? Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: Subject shot self FOUND: Natural Yes 2 V No 5 Pending Director: d in by the f Jan 20, 2007 1230 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 7155 Friendship Road, Salisbury, MD determined (Specify) Single Family To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24 | Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) January 21, 2007 OCME

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

f person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Registrar's Signature

30 Name and address

Jack Titus Mb.

			For State Registrar	State of Ma		/ Depa	artmen		Ith and N	Mental Hyg		7 033	396		
	Physici	an	1. Decedent's Name (First, Middle, Las. Edward E. Gut							2. Date of Deat	Day Ye	3. Time o			
	/Medio Examin	cal	4a. Facility Name (If not institution, give Peninsula Regional	street and number)	Cente	r	4b. City,	Town, or Loc Salist	ation of Death	Jan. 16	4c. County of D		<u>M</u>		
	uneral irector		5. Social Security Number 214-18-1636 6. Sex 12 F 84 Yrs. 16 Under 1 Year 16 Under 24 Hrs. 17 Months 16 Days Hours Min. 17 Month, Day Year 16 Month, Day Year 18 Mont									9. Birthplace (State or Foreign County) Mary Land			
e Maryland	Sa-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomic	20	10c. City,	Town or Lo	Sharp	own				10d. Inside C	ity Limits 2  No		
with th	3a or 20	i Dire	100. Street and Number 11029 Sharptown Ro	oad			10f. Zip	21837		1	0g. Citizen of What	t Country? USA			
De filed within 72 hours after deeth with the Maryland la Hvolane	f, or iteme 23 xeminer must	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	1 Never Married 2 Married 1 See 2 No If Yes, Give 4 0 / 4 / 5					nic Origin? (Spexican, Puerto	pecify Yes or No- p Rican, etc.)	American Indian, Vhite, etc.  White				
within 72 hou	then "nature the Medical I	Completed	15. Decedent's Ed (Specify only highest grad	ghest grade completed) (Give kind of work done during most of work life. DO NOT use retired)							Seafood	ess/Industry			
should be filed	Department of Health and Mentel Hygiene. important: if Iteme 23e or 28a-f ehow important: if Item 27 is marked other than "naturel", or Iteme 23e or 28a-f ehow eny injury or other treumatic event, the Medical Exeminer must be notified at once.	To Be C	17. Father's Name (First, Middle, Last) Christian Burkis		:h			Er	nestir	e Keller					
od 2 sho			19a. Informant's Name/Relationship (Type, Print)  Cecelia J. Gutermuth/Spouse  19b. Mailing Address (Street and Number or Rur  11029 Sharptown Rd.,												
Des 1 ar			20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)								20c. Location - City or Town, State				
Darkin Pages	Important: eny injury once.	4 Donation 5 Other (Specify)  SpringHillMemoryGardens 1/19/2007 Mardella SpringHillmemoryGardens of Faculty  SpringHillMemoryGardens 1/19/2007 Mardella SpringHillmemoryGardens 1/19/2007 Mardella Sp									Springs	, MD			
- ac	23a-Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximat Interval Bet					
/M	sician edical miner		Immediate Cause (Final disease or condition resulting in death)	a. Arteri Due to (or as a	oscle		Hean	t Dise	ease		<u>.</u>	Onset and			
-	ysicien and le burial-transit	Examiner	Sequentially list conditions.  Tany, leading to immudiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):												
cate be ex	physicien s the burial	ca	d												
DIVISION OF VICE INCOMES, I.O. DOX 00/00, TO the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	been signed by the ettending phys should be deteched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)								23d. Date of delivery  Month Day				
quires thet	en signed b Juld be dete	Ď	Chronic Atric Fibrillation								pacco use contribute to the cause of death? os 2 ☑No 3 ☐ Probably 4 ☐ Unknown				
The law re	ate hes bee page 2 sho	Completed	24a. Was an autopsy performer 1 □ Yes 2 □								prior death				
VILC	certifi	o Be	25. Was case referred to medical examiner?	Hospital:	nt allet	P/Outoation	2000			th (Check only one	•	2			
nding Phy	Director: After this certificate hes in by the funeral director, page 2	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1 Yes 2 No								ne 5 Residence 6 Other (Specify)  28d. Describe how injury occurred				
tal or Atte	To the Funeral Director: A completely filled in by the fu	Certification:								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
e Hospi	To the Funerel Dir completely filled in	edicai	29a. Certifier 1 Cartifying Phy (Check only one) 1 Madical Exam	rsician: To the best of inar: On the basis of and manner sta	examinatio	edge, deat in and/or in	h occurred vestigation	at the time, d , in my opinion	ate and place, n, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and	r as stated. due to the cause(s	5)		
To th	To th comp	¥	29b. Signature and title of certifier				290	. License nur	nber		d. Date signed (M				
			30. Name and address of person who c	ompleted cause of de	eath (Item 2	23a) (Type.		50759			Jan. 19,	2007			
			Charles O. Folasi	hade, MD,	108 F	inebl	-	Rd., Sa	alisbur	y, MD 21	801				
	Sta Registr	-	31. Date filed (Month, Day Year) 2 2	2007 <sup>2. Registra</sup>	ar's Signatus	A.	Spe	&							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and rtificate of Death	d Mental Hygie	
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic		Amos Gaines		January	19,2007 2:25 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death
			Prince Georges Hospital Center	Cheverly		Prince Georges
JE.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 H   Months Days Hours N	lin (Month, Day, Ye	9. Birthplace (State or Foreign Country)
la.	Director		218-16-3245		Aug. 11, 1	923 Maryland
	and	ł	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	daryl f sho	ō	Md. Charles Nanje	mov		1 X Yes 2 ☐ No
	28e-	rec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a of	Funeral Director	4200 Gaines Place	20662		USA
	death	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or Ite	Ξ	Armed Forces?  1 Never Married 2 Married   1 Yes 2 No   1 Yes 2 No   1 Yes 3 No   1	1 Yes 2 No Specify:	Jeno moan, etc.)	
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examinst must be notified at	d by	3 Widowed 4 Divorced Year or Dates:			Specify: Black
21215-0036	72 h natu	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Given	dent's Usual Occupation a kind of work done during most of DO NOT use retired)	working 16b	b. Kind of Business/Industry
7	within noe.	d L	Elementary/Secondary (0-12) College (1-4or 5+)	Rigger	1	deral Government
7	filed v Hygie other t	ပိ	6 17. Father's Name (First, Middle, Last)		Name (First, Middle, Maid	
ano	ould be Mental I	To Be	Smith Gaines	Bertha	a Holm	ies
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "natural", or Items 23a or 28e-1 show any injury or other traumatic evant, the Medical Examinst must be notified as once.	Ĕ	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or	Rural Route Number, Ci	ity or Town, State, Zip Code)
	nd 2 alth a 27 is r trat		Lavern Washington/Daughter   1790	Port Tobacco	Rd., Nanje	emoy, Md. 20662
ē,	s 1 a of Hea item othe		20a. Method of Disposition 20b. Place of Disposition cametary, cre	osition (Name of matory or other place)	Date 20c	. Location - City or Town, State
Ĕ	Page nent c nnt: If iry or		1 MBurial 2 □ Cremation 3 □ Hemoval from State  14 □ Donation 5 □ Other (Specify) Oak Gro	ve Cemetery 0		anjemoy,Maryland
Baltimore,	permit. Departr Imports any inju					neral Service
_	897 2 2 8		100	75.5		dorf, Md. 20601
ð			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on start line.	ter the mode of dying, such as care	diac or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Cardinosocular	distant	Office and Double
0	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
ä	\$ 5	be .	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ted nsit	nlne	Cause (Disease or injury			
	axecun and	Examiner	that initiated events c			
760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	call	d			
89	tifical ng ph as th		US STANKE.			
Вох	th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery  Month Day Year
E	e dea the at hed fo	Physiclan/Med	1   Yes 2   No 9   Unknown   9   Unknown   5	Other (specify)		Month Bay Four
О.	ires that the death certific signed by the attending p d be detached for use as	Phy	Part II, Dther significent conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacc	co use contribute to the cause of death?
Records,	signe bed be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w require been sign	Completed			24a. Was an	24b. Were autopsy findings available
Re	The law cate has	mc			<ul> <li>autopsy performed</li> </ul>	prior to completion of cause of death?
			25. Was case referred to medical	26 Place of	1 ☐ Yes 2 ☐ Death (Check only one)	No 1 ☐ Yes 2 ☐ No
>	Physician: r this certificatal director.	o Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	ng Home 5 Residence	e 6 □Other (Specify)
0	g Physer this	n: T	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how in	
Ö	Attending ir death. ector: After by the fune	atlo	2 Accident investigation	M 1 Tes 2 No		
Division of Vital	i in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, S.	t and Number or Rural Route Number, tate)
_	To the Hospitel within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and pl	lace, and due to the cause	e(s) and manner as stated.
	ns Ho n 24 h ne Fui	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death o	occurred at the time, date	and place, and due to the cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Han	1 225 74	mp	124/0')
	136		30. Name and address of person who completed cause of death (Item 23a) (Type 12070 Old Line Center, Ste 30		f, mo	20604
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 2 4 2007  32. Figistrar's Signature	beek		

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** James Gowans 01 27 2007 1650 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS - Braddock Campus Cumberland **Allegany** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days Hours Director 217-18-4737 Maryland February 29, 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 □ No Director Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n 23 Church Street U.S.A. 21539 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. "natural", or iter 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) event, the Med College (1-4or 5+) Elementary/Secondary (0-12) 12 Youth Supervisor Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked of traumatic ever John Gibson Gowans ပ Margaret Picken 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other traum Anna Lee Gowans - Wife 23 Church Street, Lonaconing, Maryland, 21539 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State January 31. 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** 2007 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 23a. Part . Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Argument of the control of the Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YRS disease or condition resulting in death) abstractive pulmonthy HYLONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached t 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ATRIAL FIBRICLATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No HYPERTENSION autopsy performed' DISTASE HRTENIOSCLENOTIC CARDIOVAJULAR To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Linpatient 2 ER/Outpatient 3 DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 Natural 1 Yes 2 No after death Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral DI completely filled in Tricertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 4205

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

31. Date filed (Month Dev,

4VA

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Year)

3 0

SON

912

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year JAMES GRAALMAN /Medical 01 2:54 AM 21 07 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER ARUNDEL ANNE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral**  Birthplace (State or Foreign Country) 1**X** M 2□ F Months Director 441-28-2018 JULY 1, 1930 OKLAHOMA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nowiting once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 540 POWELL DRIVE 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed Folces: 1 Mayes 2 □ No If Yes, Give Year or Dates: 1954–1956 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROCUREMENT SPECIALIST INFORMATION TECHNOLOGY 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) WALTER R. GRAALMAN ည MARY FRANCES HAWK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN R. GRAALMAN/SON 1323 ST. STEPHENS CHURCH ROAD, CROWNSVILLE, MARYLAND 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JANUARY 23 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Fyneral Service Licensee FELLOWS, HELFENBEIN, NEWNAM CREMATION AND FUNERAL CARE 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC ADENOCARCINOMA OF APPENDIX /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) Year certificate has been signed by the rector, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe ospital or Attending Physician; The hours after death, uneral Director; After this certificate by filled in by the funeral director, par 2 No 1☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) aminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

2000

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature D0062296

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE ARUNDEL MEDICAL CIMBERL FORDE

JAN 24 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year Giluer. 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Maryland Iniversity 0-5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/07/1939 Birthplace (State or Foreign Country) **Funeral** Days Hours 577-52-2519 Director Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10d. Inside City Limits 1 Tyes 24 No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12960 Millscreek Drive 20657 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced 1957-60 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appliance Technician Appliance Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James T. Gilner, Sr Helen Casserly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Gilner/Son 12960 Millscreek Drive, Lusby, Maryland 20657 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens | 01/19/2007 | Davidsonville, Maryland 21. Signature of Fure Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 SolomonsIsland Rd.,Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner olon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed es 2 this certificate 1∐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 10 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Natural
2 □ Accident 28h Time of 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital

Medical

29a. Certifier

(Check only one)

4+1

DHMH 17 Rev 1/2001

the

State

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

MD

1-14-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UI, Greene St. B 32. Begistrar's Signature 225. Baltimore 31. Date filed (Month, Day, Year) JAN 1 9 2007

State of Maryland / Department of Health and Mental Hygiene 0340 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** HUBBARD 0353AM ROLAND 18,2007 ANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner C174 JOHNS HOPKINS HOSPITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1☐M 2☐F 577-88-6743 10/13/1958 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "naturai", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No **Funeral Director** MD PG Ft. Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20744 U.S.A 7109 Pleasant Hill Drive death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify Specify: Black <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lollie Enoch James J. Hubbard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is 7109 Pleasant Hill Drive; Ft. Washington, MD 20744 Reginald Hubbard - Brother Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H
important: If ite
any Injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Pk | 01/24/2007 Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hill, MD 23a. Part1. Each the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only an cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GASTROINTESTINAL **Physician** BLEEDING DAYS /Medical Due to (or as a consequence of): **Examiner** I MONTH END-STAGE LIVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۵. 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 P ding 1 ☐ Yes 2 ☐ No death. spital or Attendiours after death.
neral Director: / 2 ☐ Accident in estigation ould not be etermined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 18, 2007 RES-000 Culius & Male, MEDICAL DOCTUR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AONAN MALIK, THE JOHNS HOPKING HOSPITAL, 600 NORTH WOLFE STREET, BACTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 4 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Funeral	***	5. Social Security Number	6. Se	х	7. Age (In y	rs. last birthday)		er 1 Yea	ar If Under 2		8. Date of Birt (Month, Da	th	9. 8		ace (State	or Foreign
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<u>a</u>		10	JAMES HUDSON ARDATH COLLINS														
Maryland	d 2 s		19a. Informant's Name/Relations DELORES HUDSON							e <i>t and N</i> umber RINE COU							2074
	s 1 an if Heal Item 2 other		20a. Method of Disposition 20b. Place of Disposition (Name of competent comp											or Tow	n, State		
Baltimore,	Pages nent of I int: If It		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			State	RESURRE				1/2	3/2007	CLIN	TON, M	ARY:	LAND	
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H			23a. Part1. Enter the disease, or shock, or heart failure. List	compl only o	ications that one cause on e	caused the de each line.	eath. Do not en	er the mo	de of d	lying, such as ca	ardiac or	respiratory ar	rest,			Approxima Interval Be	tween
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C.A.	/Medical		resulting in death)				sequence of):										
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99			IF FEMALE:	Т													
Box	death certifu e attending I nd for use as	an/h	23b. Was decedent pregnant	2	23c. If yes, ou 1 ☐ Live t	tcome of pre- pirth 2 F		Ectopic	pregnar	ncv			2	23d. Date of			
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Division	or Attendated after death Director:	ertification:	3 Suicide 6 Could r 4 Homicide determ		28e. Place build	of Injury - A ing, etc. (Spe	t home, farm, str ecify)	eet, facto	ry, offic	ee	2	8f. Location (5 City or Tow			Rural i	Route Num	nber,

State

7940 JOHNSON AVENUE GLENARDEN, MARYLAND NDU ACHUFUSI M.D. 32. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHWH 17 Rev 1/2001

Registrar

29a. Certifier

29b. Signature and title of certifier

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D21966

29d. Date signed (Month, Day, Year)

2007

JANUARY 18

20706

		Please	Type or Prir	nt in Bla	ack Ind	delible Ink.	Ensure A	II Copies	s Are I	Legible.	
		For	State of Ma	aryland				Mental Hy	giene	2007	03403
		State Registrar			Cer	tificate of	Death		Reg. No.		7
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/Medic	al	4a. Facility Name (If not institution, give		wa.	2010	4h City Town o	r Location of Death		40	2007 County of Death	
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Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birth	pplace (State or Foreign intry)
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and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
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d with giene gr tha the l	Completed	11th	College (1-40)	,,,	Ware	ehouse Su	pervisor				
be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle	e, Maiden		
ould bendarken		Paul			Huds		Ethel			John	
12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (*) Rosemary G. Hudse				ng Address (Street  Ocean (					
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		20a. Method of Disposition	511/ W110	20b. Plac		sition (Name of matory or other place		Date		cation - City or	
ages ent of rt: # h		1 Bunal 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific				cemetery Cemetery		22, 200	7 H	urlock.	Maryland
mit. F sartmo sortar 'Injur		21. Signature of Funeral Service Licer							1		isbury, MD
Ped E S		Louth	B. Lal	ley	JC	DLLEY ME	EMORIAL	CHAPE	Ĺ		21801
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each li	the death.	Do not ent	er the mode of dyir	ng, such as cardia	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a Metasta	tic	Ble	odder-	Ciena	er			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):						
ZX	j.	Sequentially list conditions,	bDue to (or as	a conseque	nce of):						
uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
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ite be ysicia ne bur	ical	•	d								
eath certificate be attending physici for use as the bu	Physician/Medica	IF FEMALE:									
ath ce ttendi	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal d	eath 3	Ectopic pregnancy	y		2	23d. Date of deli Month	very Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant a 9⊡Unknown	t time of dea	th 5∟	Other (specify) _					•
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur		Part II. Other significant conditions of	ontributing to death b	ut not resulti	ng in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
tuires n sign lld be	d by							1 🗆	Yes 2	No 3□Pro	obably 4  □Unknown
w requir s been si should	Completed							24a. Wa		24b. Were au	topsy findings available
The lav te has	шо							aut per 1⊟ Yes	opsy formed? 2 2 No	death?	ompletion of cause of
slcian: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea		_		
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To E	1 ☐ Yes > No	Hospital: 1 Impatio		R/Outpatier		4 LI Nursing F	lome 5□Res	sidence 6	6 □Other (Spec	sify)
ing P		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury	Wor		28d. Describe	how injur	y occurred	
ttend death ctor: /	Certification:	2 Accident investigation 3 Suicide 6 Could not be		uny - At hom	e farm str	M 1 □	Yes 2 □ No	28f Location	(Street an	d Number or Ru	ral Route Number,
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: V completely filled in by the fi			ysician: To the best								
n 24 h	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner st		n and/or in			urred at the time	e, date and	l place, and due	to the cause(s)
To t To t	N	29b. Signature and title of certifier	00	7		29c. Licens		0.	29d. Dat	e signed (Month	n, Day, Year)
alk.		2/2	90	MO			1627		/	-18-6	
0671		30. Name and address of person who	completed cause of c	death (Item 2	3a) (Type,	Print)	Pox 1733	9	1.1	pro:	11862
Sta	ate	31. Date filed (Month, Day, Year)	32. Registi	rar's Signatu	refer	po C	WX 1/33	001	100	no.	110
Regist		IANIOO	2007							_	

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					State of	Marylan		irtment of h <i>tificate of</i>	∃ealth and I <i>Death</i>		giene	7	03401	- }-
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	/Medic Examin		4e Fecility Neme (If no	ot institution, give		SEPH_HE ber)	SNRY H	OBBS, SR	4b. City, Town, or L		RY 1,20		7:00 pm	1
	Funeral Director	7	5. Social Security Num 162-26-36	17		7. Age (In yrs. 77	lest birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da	th	Count	ace (State or Fore	
	lend		Usuel Residence of De 10a. Stete 1	ecedent 0b. County		10c. Cit	y, Town or Loc	cation				10	Od. Inside City Lim	nits
	uth with the Marylen 23e or 28e-f show	ctor	MD	FREDER	ICK		EMMI	TSBURG					1 [☑ Yes 2 🗆	No
	with th	Director	10e. Street end Number	er	_			10f. Zip Code			10g. Citizen of	What Count	ry?	
	ne 23	Funerai	329 I	V. SETON	AVE .	ent Ever in U	.S. 13. V	21727 Vas Decedent of F	7 Hispenic Origin? (Spen, Mexican, Puerto	pecify Yes or No		A . ce - America	an Indian,	
980	urs e	<u>م</u>	1 Never Married 3 Widowed 4		Armed Fore  1  Yes 2  If Yes, Give  Year or Dat	ces? 2.∏No		Yes, specify Cub		o Rican, etc.)	Specif	ck, <b>W</b> hite, e <sup>y:</sup> WH <b>I</b> '		
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		B	17. Fether's Neme (Fir	rst, Middle, Last)					18. Mother's Nam	, .		10)		
Maryland	should nd Men marke matic	ှ	19a. Informant's Name	e/Relationship //		OND HOE		a Address (Street	Z] t and Number or Ru	TA SNEE		State. Zip	Code)	
	elth er 27 is er treu		M. ELAINE			ER.			ST. WESTM					
Baltimore,	eges 1 ent of He t: If Item y or oth		20a. Method of Dispos 1 ☑ Burial 2 ☐ 0 4 ☐ Donation 5 I	ition Cremation 3 🗆	Removal from S	20b. P	Place of Dispos emetery, crem	sition (Name of natory or other pla	ce)	Date	20c. Location	City or Tov		
altir	mit. P portan y Injur	-	21. Signature of Fune			NE		JOSEPH S Name and Addre	ess of Facility		EMMITS UNERAL	-	MD.	
_	88 58	0	John	m. ,	Skile	2			IN ST., E	EMMITSBU	RG, MD.		7-0427	
	Physician		23a. Part1. Enter the shock, or heart fa		olications that ca	used the deatl ch line.	h. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		Immédiate Cause (Fin disease or condition resulting in death)	oai	a Not	Due to (o	r as a ponsed	unceyof):	deal or	your	Mon		1 2000	_
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Box	death cert	Physician/M			d									
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<u>                                     </u>	al or At s after o l Direction by	Certification:	4 ☐ Homicide	determined	280. Place	of Injury - At no g, etc. (Specify	ome, tarm, stre	et, factory, office		City or Tov	Street and Numb vn, State)	er or Hurer	Houte Number,	
	Hospi 24 hou Funer tely fil					is of examinat			me, date and plece, opinion, death occur					
,	To the within 2 To the comple		29b. Signature and title	e of certifier	la	10	ual/	29c. Licens	se number		29d. Date signe	d (Month, D	ay, Year)	
	, 4		30. Name and eddress	of person who o	ompleted cause	of deeth (Item	23a) (Type, F		,,,,,,				l	
	10		ALAN CA	RROLL, N	4	O S. S.	ETON AV	/E., EMMI	ITSBURG, I	MD. 2172	27			
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ORIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1:45 A M Feb. 2 2007 19701 /Medical 4c. County of Peath 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Har 4928 Carea If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗙 F 178-66-0955 Director June 26, 1911 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r than "natural", or freme 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director MD White Hall Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4928 Carea Road U.S. A. 21161 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 XWidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Textiles 8 Trimmer ie marked other injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lida Durham Cleveland Waltimyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 ie n any injury or other traun Angelene Arnold/Daughter 4928 Carea Road, White Hall, MD 21161 20b. Place of Disposition (Name of company, crematory or other place)
Fellowship 20c. Location - City or Town, Slete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Feb. 5, 2007 Pylesville, MD Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. LW- Men (ci 19 S. Main Street, Stewartstown, PA 17363 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1600 disease or condition resulling in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-tran and resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) \_ detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled in by the funeral director, page 2 autopsy perform 2 No certificate 1 Yes 2 No 1 Tyes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide within 24 hours a To the Funerei C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title D0054469 February 2,200 completed cause of death (Item 23a) Pape, Scint) New Freedom PA 19349 HPrince MD (~J 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Danie ! Registrar 06

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				State of Ma		d / Depa	artme		ealth a		ental Hy		_	034	06
			1. Decedent's Name (First, Middle, Last)	<u> </u>				-			2. Date of Dea Month		Year	3. Time of	
	Physicia /Medic		Bertha M. Huffman			11					01	27	07	8:30	p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City	, Town, or	Location o	of Death		4c.	County of Deat	h	
			Garrett Mem. Hospit					land	If I lordon	04 Usa	0.0		rrett	h l (Ch-1-	C (
	Funeral Director		233 00 3330	7. Age		last birthday) Yrs.	Months	Pr 1 Year Days	If Under a	Min.	8. Date of Birt (Month, Day 02/01/	1934	Row]	hplace (State ountry) Lesburg	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside C	ity Limits
	death with the Maryland rms 23a or 28a-f show	ō	WV Preston		A11	rora								1 ☐ Yes	2 No
	28a-	Director	10e. Street and Number				10f. Z	ip Code				10g. Citiz	zen of What Co	ountry?	
	3a or	Ö	Amboy Community (I	20 Box 65	()		2	6705				USA			
	death ms 2	Funerai		2. Was Decedent 8		S. 13.	Was Dec	edent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	.	14. Race - Ame Black, Whit		
٥	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	lo			ecily Cubai	Specify:	i, rueito	riloan, etc./		Specify: Wh		
3	rel', c	d by	3₺ Widowed 4 Divorced	Year or Dates:			1 103	2,0,110	проспу.						
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N 0	Hygie ther ant, II		17. Father's Name (First, Middle, Last)			<u> </u>			18. Mothe	er's Name	(First, Middle,			•	
yland		To Be	William C. Hixenbau	ıgh					Milo	dred	Goff H	ixen	baugh		
2	s 1 and 2 should be filed w f Health and Mental Hygiei Item 27 le marked other t other treumatic event, ID	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Addre	ss (Street a	nd Numbe	er or Rura	I Route Numbe	r, City or	Town, State, 2	Zip Code)	
	5 # 2 F		Linda Huffman/ Daug	ghter		PO B	ox 6	5, Au	rora	, WV	26705				
	as 1 an of Heal litem 2 r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. P	Place of Dispo emetery, crer	sition (Nation)	ame of other place	9)		Date	20c. Lo	cation - City or	Town, State	
Ĕ	Page ment: If ent: If ury o		'4 □Donation 5 □ Other (Specify)		WV	Natio	na1	Cemet	ery (	01/3	0/07	Pru	ntytown	, WV	
Баппо	permit. Pages 1 Department of H Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Locarise	m			hape	L. Ro	w⊥esi	burg	wning F	425	al Home	, Burk	е
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause on each lin	the deat	h. Do not ent	er the mo	de of dying	g, such as	cardiac c	or respiratory ar	rest,		Approxima Interval Be	tween
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0	g Phys er this eral dir	n: To	27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time o Injury		28c. Injury Work	at		28d. Describe h				
0	Attending Price death.  ector: After Iby the funera	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOINT, Da)	, rear	injury	М		Yes 2 🗆	No					
DIVISION	A P O	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju-	ury - At ho	ome, farm, sti	eet, facto	ry, office			28f. Location (S City or Tox	Street and vn, State,	d Number or R	ural Route Nun	nber,
5	itel or rs afte rel Dia led in														
	To the Hospitel (within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier 1 Certifying Physic (Check only one)	On the basis of and manner sta	examina	wiedge, deat ition and/or in	h occurre vestigation	ad at the time on, in my of	ie, date an pinion, dea	id place, th occurr	ed at the time,	date and	place, and due	to the cause(	\$)
	To the Comp	Σ	29b. Signature and title of pertifier				- 2	9c. License				29d. Date	e signed (Mont	h, Day, Year)	
			1 ac					D002	3979		(	)1/29	9/2007		
			30. Name and address of person who cor						1, 1 '	1 1/7	0155	)			
	- 01		Robert A. Goralski 31. Date filed (Month, Day, Year)	., M.D.		N Four	en S	ı va	kland	1, 141	21550	,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 21, Day 2007 **Physician** Ruth Johnson 3:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 904 White Oak Drive Prince George's Oxon Hill If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F 218-36-3433 Director 67 April 13, 1939 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes → No Maryland Prince George's Oxon Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 904 White Oak Drive 20745 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐ Yes 2√12 No f Yes, Give 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 ☐ Widowed 4 € Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Collection Supervisor Federal Government Pages 1 and 2 should be filed nent of Health and Mental Hygint; If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caple Rufus Gracie Mae Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl E. Johnson / Son 2324 Brightseat Road Landover, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 01/26/2007 Cemetery : U1/20/2007 | Suitland, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home PA /Cedar Hill Cemetery 21. Signature of Funeral Service Licensee alas 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY **Physician** - HRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of) Examiner BRONCHIAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown Month 5 ☐ Other (specify) P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1√2 Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director; the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 2 4 2007 Registrar

9131 PISCATAWAY CLINTON スd 32. Registrar's Sign Iture

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Victor E. Herry

1-22-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January17, Day 2007 Year Physician DONALD JONES 10:00 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examine Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F 70 Vrs 578-44-9024 Director 28. 1936 Washington, D.C. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 R Yes 2 □ No r 28a-f sh notified Maryland Silver Spring Director Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or dir al Examiner must be r Pages 1 and 2 should be filed within 72 hours after death with 20902 United States 901 Arcola Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: altimore, Maryland 21215-0036 Specify: Black à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Automobile Mechanic Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H Be Trene Edmonds Wilbert Jones, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau once. 20910 <u> Elaine Jones Wilson /Sister</u> 8600 16th Street #402 Silver Spring, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Jan. 25, 2007 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Eacility ope P.A. 5538 MariboroPike/Forestville, Md. 21. Signature of Funeral Service Li 20747 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, Immediate Cause (Final disease or condition resulting in death) **Physician** Perforated Viscus Days /Medical Due to (or as a consequence of) Examiner Sepsis w/Septic Shock Sequentially list conditions, if any leading to final clat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Multi Organ Failure Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 🗆 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HTN 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No tal or Attending Physician: The safter death.

al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

1119 Rockville Pike Ste. 100 Rockville, Md. Saima Khawayi, M.D. 31. Date filed (Month, Day, Year, 32. Registrar's Signature

30. Name and address of person who completed cause of death (It and 23a) (Type, Print)

JAN 24 2007

29b. Signature and title of certifier

29c. License number

D0058965

29d. Date signed (Month, Day, Year) January 17, 2007

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Johnson 2007 Gerald /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISKIM Niconio Teninsum REGIONOS MEDICOS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1**X** M 2□ F 229-26-1162 12/23/1930 Tennessee 76 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Wicomico Salisburv 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 4171 Coulbourne Mill Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. African/ filed within 72 hours after 1 Never Married 2K Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 American þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health, and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, the once. Music Educator Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lubertha Leeper Frank Daniel Johnson ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4171 Coulbourne Mill Rd., Salisbury, MD 21804 Maxine Johnson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 1/24/07 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Holloway Fufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kelt leve 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myocardner one hour **Physician** /Medical Due to (or as a consequence of): **Examiner** 15 year ASW Sequentially list conditions, if y leading cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bate has been signed page 2 should be det Records, Completed by 2 4 No 3 Probably 4 Unknown 1 🖺 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1∐ Yes Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DR. USHA NATESAN Do51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALISBURY

32. Registrar's Signature

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

Barbara Krumwiede

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State of Maryland / Department of Health and Mental Hygien®

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Funeral Director		5. Social Security Number 467-68-0825		M 2√2 F	. Age (in yrs.	last birthday) Yrs.	Months		Hours	Min.	8. Date of (Month, 1-4	birth Day, Ye IQ17	ar)	Cou	ntry) TEX	te or Foreign
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permit. Pagas Depertment of Important: If I any Injury or once.		21. Signature of Funeral S	Service Licens  10 50	weß	M005	S					, P.A			MAIN BURG,		
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												Approxin Interval 8 Onset an	Between	
ficate be executed XX physician and sthe burial-transit	dical Examiner	d														
raquiras that tha deeth cartifics taan signad by tha ettending ph hould ba datachad for usa as t	Physician/Med	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	pirit		th 2 ☐ Feta ntattime of c	ldeath 3□	Ectopic p Other (s	pecify)				-		ate of deliv	ery Day	Year
uiras thai signad t id ba dat	þ	Part II. Other significant (	conditions co	ntributing to dea	ith but not res	sulting in the u	nderlying	cause give	en in Part I.				o use cor 2 □ No	ntribute to t		of death?
≥ <u> </u>	Completed										24a. W	as an	24b.	. Were auto	psv finding	s available
a - a	E										pe	topsy formed		death?	mpletion o	cause of
lan: Th rtificata stor, pag	0	25. Was case referred to	riedical						26 Place	of Death	1 ☐ Yes		No	1 🗆 Yes		6HTERS
Physician: this cartific rel diractor,	ToB	examiner? 1 Yes 2 No	F	Hospital:	patient 2□	ER/Outpatien	t 3 D	OA Othe	r		ne 5□Re		6 FPO	her (Specia	-	Hone
arthi		27. Manner of Death	1	28a. Date of		28b. Time of		28c. Injury Work			8d. Describ				7/	A115
Attending In death.	ate	1 ☐Natural 5 ☐ 2 ☐ Accident	Pending investigation	(MOTILI)	Day (Gal)	Injury	М		r res 2 🗆 l	No						
2 = = 2	Certification;	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of building	f Injury - At h g, etc. <i>(Speci</i> i	ome, farm, str	eet, factor	y, office		2	8f. Location City or 1			ber or Run	Al Route No	umber,
Hospit 4 hour Funer (aly fills	edical	29a. Certifier 12 C (Check only one) 2 M	ertifying Phy edical Exami	sician: To the bas ner: On the bas and manne	is of examina	owledge, death ation and/or inv	occurred estigation	at the tim	e, date and pinion, deat	d place, a	and due to the	e cause e, date a	(s) and m and place,	nanner as s , and due t	tated.	<b>9</b> (s)
To the within 2 To the complain	ž	29b. Signature and title of	certifier	1.1			29	c. License	number			29d. [	Date sign	ed (Month,	Day, Year,	)
		•	11	/vag	9-6	ans		D	22	181		T	mus	My 5	292	007
1		30. Name and address of								.01			/ * ) * 1 E	1	1	V /
4		GARY L. WAGO						CUM	IBERLA	AND,	MD 21	502				
Sta Registr		31. Date filed (Month, Day	. Year)	400	gistrar's Signa	ature	0.50									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AMUER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9/27/1930 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sext 1 S.M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours Yrs. 76 New York Director 065-24-1878 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number itema 23a or 21409 997 Hillendale Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any njury or other traumatic event, the Medical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: δ 3 Widowed 4 Divorced 1951-61 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Morris Lipka Sylvia Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 936 O Street, N.W., Washington, DC 20001 Lori Ann Lipka/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Cemetery 1-21-07 Annapolis, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home May M 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) MINTE Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed use as the burial-transit this certificate has been signed by the attending physicien and al director, page 2 should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t al or Attending P s after death. Il Director: After t Certification: 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 15 Certifying Physician: To the ceal of my knowledge, death consined at the time date and date and due to the retuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of ceffifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) egistrar's Signature State 2007 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 19, 2007 **Physician** 6:55 P M Ruth LOESERMAN /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F New York Director 126-16-6926 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene, and the filed Hygiene, and if the a Z1 is an exted other than "natural", or tiems 23a or 28a-f show ant: if them 27 is an exted other than "natural", or tiems must be notified at ury or other traumatic event, the Modified at 1 Yes 2 No Rockville Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 6111 Montrose Road #921 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advertising Market Researcher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Lapman Charles Rosenthal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 40-40 74th Street, Elmhurst, NY Susan Friedman, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page Department of Important: If any injury or once. Union Fields Cemetery 01/22/07 Queens, NY 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Weeks Metabolic Encephalopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transIt Due to (or as a consequence of): O. Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 ANo 24b. Were autopsy findings available prior to completion of cause of death? page 2 No 1 Yes Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4K Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA ō 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Division 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier unler MO January 19, 2007 D 0036716 3 mden 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 Andrew Kundrat, M.D., 6121 Montrose Road, Rockville, MD egistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

JAN 23 2007

oess rman,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 2007 0239 M ease anualy 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Memorial EASTON TALbo HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 7, 1967 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 2/6\_ 02-39/6 Usual Residence of Decedent Yrs. Director Maryland death with the Maryland 10a State 10c. City Town or Location 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner it was be notified at Cordova 1 ☐ Yes 2 ₺ No Director Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2162 Koao by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. t Never Married 2 Marned 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 7 is marked other then "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Worked Vever 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland Be Pages 1 and 2 should be and Mental Fred Blocker 2 case trances enick ouise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is eny injury or other traignes. 30931 Robbit Hill Road Cordova, Maryland 21625

20b. Place of Disposition (Name of cometery, crematory or other place)

Date

20c. Location - City of Town, State Brandt 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Mid Shore Cremation Cambridge, Maryland 107 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY FUNERAL HOME, P. A. 5 io washington Str Caubridge, Maryland 21613 23a. Part t. Enter the disease, or complications that caus a the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final pertension Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Obaschi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificete 2 No 1 Yes 2 No 1 Yes : After this certifice funeral director, I 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending t ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: Al completely filled in by the fu

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

pleted cause of death (Item 23a) (Type, Print)

4410

Hrowsh MP

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

217 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00044242

Pt. Pd.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:30 PM Joseph 2007 M Lappin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6572 Ouantico Road Quantico Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1ĂM 2□ F 3-17-1950 56 Maryland Director 217-54-7306 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Examinar must be notified at once. 1X Yes 2 No Director Quantico MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21856 USA 6572 Quantico Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Forces?

1 Tyes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2X Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer 12 State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Costen Joseph T. Lappin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 42, Quantico, MD 21856 Ann Lappin - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Wicomico Memorial Pk. 1-25-07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease or condition resulting in death) mo Cerce **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year φ 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of ceath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 1 ☐ Yes 2 ☐ No been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Inpatient Other: 1 Yes 2 No 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 4 Nursing Home this After this funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 2 No 1 TYes 2 Accident after death Director: / in by the f 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within To the 29d. Date signed (Month, Dey, Year)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature

30. Name and auc Alon

31. Date filed (Month, Day, Year)

Davis

JAN 24 2007

**ORIGINAL** 

MY

100 Power

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print

29c. License number

D54127

mn

21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	Marylar			t of H	ealth a			ené () () 7 g. No.	03417
	Physici	an	1. Decedent's Name (First, Middle, La	ist)	-						2. Date of Death Month	Day Year	3. Time of Death
7	/Medic		Chris C. Ligi				,				Januar		
	Examin	er	4a. Facility Name (If not institution, give		er)		4b. City,		Location o	f Death		4c. County of Dea	
			Union Hospita  5. Social Security Number 6.5		Ane (In vrs	last birthday)	If Under		cton	24 Hrs.	R Date of Ridh	Ceci	
	Funeral Director			1 <b>X</b> M 2□ F	54	Yrs.	Months	Days	Hours	Min.	ecembe.	<sup>9. Bi</sup> r 31, 195	rthplace (State or Foreign ountry) NJ
	D .		Usual Residence of Decedent  10a. State 10b. County		10e Cit	ty, Town or Lo	nation						
	ehov	'n			100. CI								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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2	with with	ă	20 Country L	ano			101. ZID		921		10	•	J.S.A.
	m 2;	Funerai	11. Maritaf Status	12. Was Decede	nt Ever in U	.S. 13.1	Was Deced			gin? (Spec	cify Yes or No- lican, etc.)	14. Race - Am	
0	or ite	Ē	1 <b>X</b> Never Married 2 Married	Armed Force						, Puerto P	lican, etc.)	Black, Wh	
3	within 72 hours after death with the Maryland iane. Than "naturel", or iteme 23a or 28a-f ehow Ine Madical Examiner must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes	MC NO	Ѕреспу:			Specify:	White
0000-01717	"nett	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usua kind of woi DO NOT us	il Occupa k done o	ation during most	of workin	g 1	6b. Kind of Business	s/Industry
4	within 72 ane. than "na"	F	Elementary/Secondary (0-12)	College (1-4d	or 5+)		emar:					Telemar	ketina
	Tryg		17. Father's Name (First, Middle, Last	·)		101				r's Name	(First, Middle, M		Reding
0	l Mental Narked c	To Be	Howard P. Lig	ghtner					Edi	ith :	Lane		
<u> </u>	Should be man		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rural	Route Number,	City or Town, State,	Zip Code)
	end 2 Beith a n 27 is	٤,	Pam Connell/S	ister		9 S	haro	n's	Way	, Wi	lmingt	on, DE	19808
	of He of He if iten or oth		20a. Method of Disposition 1 Burial 2X Cremation 3 [	Removal from Sta	20b. F	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	e) Jar	Da Tuar	v 24.	oc. Location - City o	r Town, State
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	permit. Pages 1 Depertment of H Important: if Ite eny injury or ot once.		21. Signature of Funeral Service Lice			Δ.	ndra	w C	Coc	y 3 Fili	noral	UOMO	
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,000,	ate be executed //Medical Examiner Ibe purial-transit	ilcai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentiafly fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or C.	as a consequence of the conseque	uence of):  My(  juence of):	vest occro cthy	lial	Ju sev	fere	tion		Onset and Death
.O. DOX 00	of the death certification by the attending phisached for use as the	Completed by Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. ff yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Feta t at time of c	ıldeath 3⊑	Ectopic pr Other (sp					23d. Date of de Month	slivery Day Year
Σ ]	The law requires that the taken the steep signed by the sage 2 should be detached.	y Pt	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did toba	acco use contribute t	to the cause of death?
vital necords,	w require been sig should b	ed	Coronory	artery	dis	sewe					1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
ָ מ	as be	pie	End Steg								24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
		S	V								perform	ed? death? ⊒No 1 □ Ye	1/
10	ician: Th cartificate ractor, pag	Be	25. Was case referred to medical examiner?	Openited: No. 16				100		of Death	Check only one		
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=	ding F h. After funera	ion	1 Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	M	8c. Injury Work	rat c? Yes 2∐N		8d. Describe hov	vinjury occurred	
DINISION OF	ten for: the	fical	2 Accident investigation 3 Suicide 6 Could not to	00 - 04	Iniury - At h	ome, farm, str					8f. Location (Stre	eet and Number or F	Rural Route Number
	el or s eftar i Dire d in b	Certification;	4 Homicide	building,	etc. (Specii	(y)	,				City or Town,	State)	
	To the Hospital or At within 24 hours effar or To the Funerel Direct completely filled in by	Medicai (	29a. Certifier 1 Certifying P (Check only one) 2 Nedical Exa	hysician: To the be miner: On the basis and manner	s of examina	owledge, death	n occurred vestigation,	at the tim	ne, date and pinion, deat	d place, ar	nd due to the cau d at the time, dat	use(s) and manner a e and place, and du	s stated. e to the cause(s)
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			Sign ben	gon //1			0	000	6075	56		1/24/20	07
			30. Name and address of person person	ompleted cause of	of death (Iter	п 23а) (Туре,	Print)	2 1 1	00	0 '	< + C	1 11 1	
	Sta	10	31. Date filed (Month, Day, Year)	9 C 7	n 1)	ature	123	5 W.	VY)(	in	21,6	KTON.	10
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State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year  $P_{M}$ **Physician** JANUARY 21, 2007 12:05 FRANCIS EMERSON LARKINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **X** M 2 □ F Yrs. 77 MARCH 26, 1929 MARYLAND Director 213-26-4064 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show in and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, Ina Medical Evontrantinat ke motified at 1 Yes 2 No STEVENSVILLE MARYLAND QUEEN ANNE'S Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21666 **USA** 1103 CHESAPEAKE DRIVE Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 **T**Yes 2 NP947 — If Yes, Give Year or Dates: 1950 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MARYLAND GENERAL HOSPITAL 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ဂ FRANK LARKINS MYRTLE VOGEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1103 CHESAPEAKE DRIVE, STEVENSVILLE, MARYLAND 21666
29 of Disposition (Name of Date 20c, Location - City or Town, State item 27 other tra JUDY PAUL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition JANUARY 22, permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 XCremation 3 Removal from State ^4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signature of Funeral Sovice Incensee FELLOWS, HELFENBEIN, AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MD 21619 Dee plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or com shock, or heart failure. List only cancer of unknown Immediate Cause (Final letastatic week **Physician** /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day ь in the past 12 months? 5 Other (specify) ☐Yes 2☐No o. 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 No 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 28d. Describe how injury occurred 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Certification; After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deatl 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 5 m 30. Name and address of pers iple ed cause of death (Item 23a) (Type, Prin Stevensville, MD ove Point Road #107 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:00 A M **Physician** LaValley Gary A. 17, 2007 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel 503 Wood Duck Lane Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Months **1** 2 □ F 55 480-58-1121 Iowa Aug. 30, 1951 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Anne Arundel Annapolis 1 Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21409 U.S.A. 503 Wood Duck Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Naval Academy Archivist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Jones George D. LaValley ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary LaValley/wife 503 Wood Duck Lane Annapolis, Maryland 21409 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page:
Department o
Important: If i
any Injury or Baltimore Crematory 1/20/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 add 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 months Due (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tra Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 Yes 2 No 1 TYes certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, å Hospital: Other: 4 ☐ Nursing Home 5 🖬 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 🔲 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend s after death, il Director; / filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff

To the Funeral D

completely filled in Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadway, Baltimore, Maryland 21231

State Registrar

Messesmith MO 31. Date filed (Month, Day, Year) 32 degistrar's Signature 2007

401 North

Am	end#23a,2 dME. 1/19	23aE	Please Part II,25,27,28-28F AMGO Health Dept. Of Registrar	e <b>Type or Print in I</b> AH State of Marylar	nd / Depa		of He	alth and I	Mental Hy	_	le. 07 03420
	Physici /Medi		1. Decedent's Name (First, Middle, L	ast) LE	Û				2. Date of De. Month	ath	3. Time of Death 4:56a
7	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, T	own, or L	ocation of Death	1	4c. County of	DeathAnne Arundel
	<u></u>		Anne Arundel Me 5. Social Security Number 6.		to a bioth do 1			olis If Under 24 Hrs.	1 0 D ( D)-	0	716
	Funeral Director		034-10-0006 Usual Residence of Decedent	7. Age (in yrs. 108.M 2 F	Yrs.			Hours Min.	8. Date of Bird (Month, Da Apr. 2	6, 1919	9. Birthplace (State or Foreign Country) NY
	Maryland B-f show	tor	10a. State 10b. County	Arundel 10c. Ci	ty, Town or Lo		erna	Park			10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 725 Dividing F	Road		10f. Zip (		1146		10g. Citizen of Wh	nat Country? USA
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiane. odder then "naturel", or Iteme 23a or 28a-f show event, I're Medical Exertifier must be notified at	þ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 1 Mayes 2 □ No If Yes, Give Year or Dates:		Was Decede If Yes, specif 1 ☐ Yes 2	fy Cuban,	panic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		- American Indian, White, etc. White
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121	within ane. then "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)			T.:	aw
and 5	uld be filed v fental Hygia rked other t tic event, II	To Be Co	17. Father's Name (First, Middle, La Patrick D. Leo	5+ st)		- Sawy	1		ne (First, Middle, noenlebe	Maiden Sumame	
Maryland	ss 1 and 2 shou of Heelth and N item 27 is mai r other traumai	_	19a. Informant's Name/Relationship Dorothy Leo/Wife						ral Route Numbe everna P	er, City or Town, Si ark, MD	tate, Zip Code) 21146
Baltimore,			20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Content of the Conte	☐Removal from State	Place of Dispo cemetery, crei ew Cath	matory or oth	her place)		Date 1. 13,	20c. Location - C	ity or Town, State
Balti	permit. Page Department Important: if eny injury or		21. Signature of Buneral Service Lic	ensee	2 <u>2</u>	Name and Barran 195 Go	Address CO & V. R:			erna Parl erna Parl	k Funeral Home k, MD 21146
	Physician /Medical Examiner		23a. Pay. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the dea by one cause on each line. So a.  Due to (or as a consect by the	XLQ (!	ter the mode Hematon	of dying,	such as cardiac	or respiratory and	NA A	Approximate Interval Between Onset and Death N30 Days
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i a	sician: Th certificate rector, pag	BeC	25. Was case referred to medicat examiner?				2	6. Place of Dea	th (Check only o		
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Ē		on:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		c. Injury a Work?	t		now injury occurred	1
Division	or Atten fler deal Sirector: in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At h building, etc. (Speci	tome, farm, str	M 1 □ Yes 2 2 No Fall At Home  m, street, factory, office 281. Location (Street and Number or Rural Route Num. City or Town, State)					
_	To the Hospitel or Attenwithin 24 hours efter deatl To the Funeral Director: completely filled in by the	edical Co	29a. Certifier Certifying I (Check only 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and xaminer: On the basis of examination and/or investigation, in my opinion, death and mannenglated.					, and due to the	cause(s) and mann	Severna Park, MD ner as stated. d due to the cause(s)
	To the Fo the complex	Me	29b. Signature and title of pertifier	1 2/1		29c.	License r			29d. Date signed (	(Month, Day, Year)
			30. Name and address of person wo	o completed cause of death (Ite	7/ W) m 23a) (Type	Print	)	214	38	01.10	0.07 PolyMDzifol
50	Sta	ate_	31. Date filed (Month, Day, Year)	CIEWA WM  32. Degistrar's Sign	449	TIDE	YEN	ISE An	GHWA	ANNE	Pary M Drifol
12.	Regist		IAN 1 9	2007	A A	Small s	,				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) PM James Wilson Macey 18, January 2007 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Anne Arundel Ginger Cove Health Center Annapolis If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days 1 XM 2 ☐ F 214-05-0137 95 July 1, 1911 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location Annapolis 1 ☐ Yes 2 No Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4000 River Crescent Drive 21401 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 MayYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Specify. ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bank Treasurer Banking 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grover Cleveland Macey Alva Pettebone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth A. Bell/niece 1173 Tyler Avenue Annapolis, Maryland 21403 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Margaret's Cemetery 1/22/2007 Annapolis, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service License 147 Duke of Gloucester St., Annapolis, MD 21401

Physician /Medical Examiner Physician/Medical Examiner

Physician

/Medical

**Examiner** 

Director

<u>^</u>

Completed

Be

2

**Funeral** 

Director

2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show

Pages 1 and 2 s ment of Health an

Saltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show they hipry or other traumatic event, the Medical Examiner must be notified at once.

requires that the death certificate be executed the burial-tran signed by page 2 this certificate To the Hospital or Attending Physician: funeral director, After within 24 hours after death.

To the Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

23a, Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		ie of dying, such as cardia			interval Between Onset and Death						
disease or condition resulting in death)	Due to (or as a consequence of):  b.  b.											
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that initiated events resulting in death) Last	c	uence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic p			23d. Date of del Month	ivery Day Year						
Part II. Other significant conditions	contributing to death but not resu	Ilting in the underlying (	cause given in Part I.	23e. Did tobacc	1.	the cause of death?						
				24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 ☐ No						
25. Was case referred to medical			26. Place of De	ath (Check only one)								
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 Residence	6 □Other (Spe	cify)						
27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in								
3 Suicide 6 Could not 4 Homicide determined		ome, farm, street, factor	y, office	28f. Location (Street City or Town, Sta		ural Route Number,						
29a. Certifier (Check only one)  Check only one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place n, in my opinion, death occ	ce, and due to the cause curred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)						
29b. Signature and title of certifier	e mm mo	29	c. License number		Date signed (Mont	th, Day, Year)						
30 Name and address of person who	o completed cause of death (Item	23a) (Type, Print)  Pefense		rotton,	MD 2	1114						

13 State

Registrar

Medical Certification: To Be Completed by

31. Date filed (Month, Day, JAN 22

2007



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 14, 4:00p M 2007 January Gladys Elizabeth Mitchell **\*Medical** 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince Georges Upper Marlboro 4209 Duchess Ct. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕱 F 29, 1959 Washington, D.C. July Director 47 577-80-1466 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1X Yes 2 No Director Upper Marlboro Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 United States 4209 Duchess Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government/ IRS Infomation Tech. Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Delcia Ball Norman Hawkins, Sr. traumatic 2 permit. Pages 1 and 2 should Department of Health and Me Important: If Item 27 is mark any injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4209 Duchess Ct. Upper Marlboro, Md. Andre' R. Mitchell / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1₺ Burial 2 □ Cremation 3 □ Removal from State Jan.19, 2007 Suitland, Md. Cedar Hill 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pike/Forestville, Md. 23a. Part I. Enter the disease, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final Colore ctal Physician cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \$\mathbb{E}\$ Residence 6 Other (Specify) 1 ☐ Yes 21X No P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examiner i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760. Division or Vital Records, P.O.

death with the Maryland

filed within 72 hours after

other

Pages 1 and 2 should be 1 nent of Health and Mental int: If Item 27 is marked o

Baltimore, Maryland 21215-0036

Certification: Medical

To the Hospitai within 24 hours a To the Funerai E

State Registrar 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. PHUSILIAN

29c. License number D53590

29d. Date signed (Month, Day, Year) JANUARY 19, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Room SYDNEM DY MO

624 N BROADWAY BALTIMORE

31. Date filed (Month, Day, Year)

29b. Signature and title of certific

3☐ Suicide

29a. Certifier

4 Homicide

JAN 23 2007

6 Could not be

determined

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2 Date of Death 1. Decedent's Name (First, Middle, Last) Tanuary 20, 2007 **Physician** 6:00AM PAULINE VIRGINIA MOYE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **DOCTORS** HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 🗶 F VA Director 578 24 8560 90 9-17-1916 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 No Director WASHINGTON DC the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 107 50TH STREET NE 20019 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify. Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UNIVERSITY OF MARYLAND COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VINCENT KELLY LUCY LAWRENCE ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARJORIE B. ADAMS/GRANDDAUGHTER 7924 BEECHNUT RD, CAPITAL HEIGHTS, MD 20743 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State LINCOLN CEMETERY 1-26-2007 4 □ Donation 5 □ Other (Specify) BRENTWOOD, MD 22. Name and AMARSHAUL'S FUNERAL HOME OF MD, INC. 4308 SUITLAND RD, SUITLAND, MD 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pheumonia disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Cardiac arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that littless of total the cause of the Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown stage Reual 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☐ Yes 2 □ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

To the within 2

29b. Signature and title of certifier

Chalak

MD

7500 Manover

29c. License number

D0056986

PKWY Suite 15 Greenbelt Me 20770

29d. Date signed (Month, Day, Year)

1/20/07

and manner stated.

Berzingi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print The Chilan Der Zing: 7500 Mahover III

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Jan 22 2007 **Physician** 10 AM Edith Belvie Mutter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5770 Long Beach Drive St. Leonard Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 9 1917 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 □ √ 414-05-1896 89 Virginia Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Calvert Director St. Leonard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5770 Long Beach Drive 20685 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itel any injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married f Yes, Give 'ear or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 💢 o Specify Specify: white ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8th homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Stewart unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gerald Mutter- son 5770 Long Beach Drive St. Leonard MD 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Funeral Service Alexandria Virginia 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician LUN Canco. disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an autopsy performed? Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of pown who completed cause of death (Item 23a) (Type, Print) Prince Frederick MO201078 110 HOSPI 31. Date filed (Month, Day) 32. Registras Signature 2007

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Elaine McIntyre 20,2007 January 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8685 Riggin Road Mardela Springs

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 5,1945 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 N F Director 61 219-42-9181 Westover, MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any Injury or othar traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 XNo Director MD Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21837 Funeral 8685 Riggin Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Financial Center Manager Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Thurman 0akley Peterman, Sr. Anna Mae Rapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darrin Boog- Son 8685 Riggin Road Mardela Springs, MD 21637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Ga. 1/27/2007 Hebron, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee Pelisse Haun 705 E Main Street Salisbury, MD 21804 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breas7 9 40005 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dura to for an a nonmaditional offi-Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 Yes 2 **N**No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 030690 Jan. 22 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 145 E. Grall Ft. Jolisbury James E. MARTIN 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State JAN 2 3 2007 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / State Amended 28e,1/26/07,LDB,DOR Registrar	Department of H	lealth and N Death	lental Hyg	giene Reg. NoO A A 7	031.26
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath C	3. Time of Death
ы	Physicia		Geraldine Frances Mitschke			Month 1 - 14.	Day Year	1346 M
A.	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	th
		71	YENINGUA REGIONAL MEDICAL CENTEL	SA	KISBUNJ		Hicom.	1CO
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct. 14	, Ye <i>ar)</i> 9. Bin C , 1931 Mar	thplace (State or Foreign ougtry) y Land
	pu v		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tox	wn or Location				10d. Inside City Limits
1	faryla shor	P		uitland				1 X Yes 2 □ No
//	the N 28a-1 notifie	Director	Maryland Wicomico Fr	10f. Zip Code			10g. Citizen of What C	ountry?
4	death with the Maryland ms 23a or 28a-f show r must be notified at		111B Linda Drive	21826			USA	
_	ms 2	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Whi	
21215-0036	urs after al", or ite Examine	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Married 2 Married 1 Never Married 2 Marr	1 ☐ Yes 2 XNo	Specify:	Tilodii, etc.		hite
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2	ed wi ygien yer th	S		lomemaker	19. Mothor's Mam	o /Eirot Middlo	Own Hom  Maiden Surname)	<u> </u>
Maryland	be fill d out	Be	17. Father's Name (First, Middle, Last)  Charles Preston Smith, Sr.			ie Mae I	_	
ĭŽ.	hould d Mel marke matic	은		9b. Mailing Address (Street				Zin Code)
Ma	d 2 s Ith an 17 is i		Julius Mitschke/Husband	P. O. Box 18				
ē,	Heal Heal tem 2		20a Method of Disposition 20b. Place	of Disposition (Name of tery, crematory or other place	i i	Date	20c. Location - City o	
30	Page ent of nt: If i		1 X Burial 2 Cremation 3 Removal from State	nill Memory Ga:	in the second	/2007	Hebron, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Livensee	22 Name and Addre	ss of Facility		Box 3171 Salisbury,	MD 21802
			23a. Part. Enter the disease, or complications that caused the death. Do					Approximate Interval Between
	Physician	5	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 t.	,			Onset and Death
1	/Medical		disease or condition resulting in death)  a. Silb like to condition a. Due to (or as a consequence	e of):				7 3
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JI is	₽ .≒	iner	Sequentially list conditions, if any, leading to immediate cause. Ent of Jacobian Sequence Cause (Disease or injury	e of):				
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687	icate phys s the	dici	d					
Box (	leath certifica attending ph I for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant				23d. Date of de	efivery
	death e atte d for	Physician/Medical	in the past 12 months?  1 \( \text{Ves} \) 2 \( \text{No} \) \( \text{No} \) \( \text{Ves} \) 2 \( \text{No} \) 2 \( \text{Ves} \) 2 \( \text{No} \) 2 \( \text{Ves} \) 2 \( \text{No} \) 2 \( \text{No} \) 2 \( \text{Ves} \) 2 \( \text{No} \) 2 \( \text{Ves} \) 2 \( \text{No} \) 2 \( \text{Ves} \) 2 \( \text{No} \) 2 \(		у		Month	Day Year
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	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause giv	en in Part I.	23e. Did to	obacco use contribute res 2 No 3 ☐ F	to the cause of death?  Probably 4 □Unknown
Ö	w require been sig	eted				24a. Was		utopsy findings available
Vital Records,	has l	Completed				autop	osy prior to rmed death?	completion of cause of
g			25. Was case referred to medical		26. Place of Dea		2 No 1 ☐ Ye	s 2□No
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o	or Attending Physician: ifter death. Director: After this certifica in by the funeral director,	1-	27. Manner of Death 28a. Date of Injury 28b	b. Time of lnjury 28c. lnjur			now injury occurred	
io	tending leath. tor: After the funer	atio	1 Natural 5 Pending 2 Accident investigation (World), Day Year)		Yes 2 No	tall	at home	
Division	r Attender death	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
Ö	talor rs afte ral Div	Certification:	Home					ury, md 21803
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier (Check only (Ch	ge, death occurred at the ti and/or investigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	thin 2 thin 2 the mplet	Medical	one) and manner stated.  29b. Signature and title of certiler	29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)
	7 with	=		H	50447		1/19/07	
			30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	JO 11/		11-110	
			Chris snyder 100 & Carroll ST.	SAUSBUM M	0 2/10	7		
	St	ate	31. Date filed (Month, Day, Year) 32. Signature	SAUSBUY M				
	Regist	rar	JAN 2 3 2007 June 15	Speciel .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Jason Stephen M	4	- For State	State	of Maryla		rtment of tificate of	f Health and f <i>Death</i>	d Menta	ıl Hyg		eg. No.	000	1 001.0
Registrar Physician/ 1. Decedent's Name (First, Middle,Last)					2. Date of Death Month Day Year			3. Time of Death					
Medical Examir	er	Jason Stephen Morter					Janua			January 3	1, 2007		1245 hrs
po de de mario	ı	4a. Facility Name (if no 120 Wood Rd	ot institution, give	e street and nur	mber)		4b. City, Town, or Aberdeen	b. City, Town, or Location of Death  Aberdeen			4c. County of Death  Harford		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs			7. Age (In yrs. la	ast birthday)	If Under 1 Yea					Foreig	thplace (State or
Director		215-19-743	31 <sub>1</sub> <u>x</u>	M 2 F	21	Yrs	Months Days	s Hours	Min.	Feb.	19, 1985 Country) NY		
, a	ŀ	Usual Residence of De	ecedent c. County		10c City	Town or Locat	ion						10d. Inside City Limits
ow ar		MD	Harfor	ď		erdeen							1 X Yes 2 No
uryland	Director	10e. Street and Number	er			10f. Zip Code				1	0g. Citizen of	f What Cour	ntry?
the Ma a or 28	Öİs	120 Wood	l Road				2100	1			U.S.	Α.	
th with	Funeral	11. Marital Status  1 X Never Married	2 Married	12. Was Dece Armed Fo	edent Ever in U. orces?		as Decedent of His es, specify Cubar					tace - Ameri Vhite, etc.	ican Indian, Black,
er deat	필	3 Widowed		1 Yes If Yes, Give Year	2 🔀 No	1	Yes 2 X No	specify:			Spec	ify: Whi	te.
urs aft. tural"	<u>چ</u>	15. Decedent's Educa	L	or Dates:		16a. Deceder	nt's Usual Occupat	tion (Give kir				f Business/I	
5 72 hor n "na	Cornpleted	Elementary/Secondary (0-12) College (1-4 or 5+)				during most of working life. DO NOT use retire				Construction			
D036 within iene.	gu	12 17. Father's Name (Fir				Labo	rer	19 Mather's	Nama (E	irst Middle	Maiden Surna		ion
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiere. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be Co	Stephen							M. S		ivialueri Surri	anie)	
21, nould be id Men is mar	2	19a. Informant's Name			\		g Address (Stree				nber, City or ryland		
MD and 2 sho salth and 27 is raumati		Kim Kort		Mother,			Wood Rd.			err, Mar Date			Town, State
Baltimore, bermit. Pages I at Department of Her Important: If ite		1 Burial 2 🔀	Cremation 3				ther place)		2/6/0	07	1		ter, PA
Itim nit. Pa artmen ortant	- 14	4 Donation 5 21 Signature of Funer					Name and Addreed		na.	ral Ho	me P	Δ	
Depr. Jump	-13	KIRSKA	4m/h/	Contex	obce	A	berdeen,	Mary.	Land	2100	1-3399		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and											
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Methadone intoxication  Death  Due to (or as a consequence of):								Death			
		Sequentially list conditions,  b.											
, pura e sile.	iner	if any, leading to imme	ediate	Due to (or as a	consequence of	of):							
=	Examiner	(Disease or injury that events resulting in dea		Due to (or as a	consequence of	of):							
O, e be executed ysician and burial - transit		[V] INIGENIES	d.	AMENDED									
0, e be er ysiciar burial	ledical	X UNPENDED		#23a,P	II,27,28	-f. perM	E. g864 2/	8/07 TI			23d Da	te of deliver	v
Box 6876 e death certificate the attending phy	Physician/M	IF FEMALE: 23b. Was decedent pre past 12 months?	egnant in the	1 Live b		2 F	etal death 3	Ectopic	oregnand	СУ	Mon		Day Year
OX (eath ce ath ce attence attence)	/sici	1 Yes 2 No	9 Unknow		nant at time of de own	eath 5 0	ther (Specify)						
O. B at the da by the		Part II. Other signific	ant conditions	contributing to	death but not i	resulting in the	underlying cause	given in Parl	:1	23e. Did t	obacco use o	contribute to	the cause of death?
, P.O. ires that to signed by	d by	Cocaine	e use							1 Ye	es 2 No	3 Prol	bably 4 V Unknown
rds v requi	Completed	2.								24a. Was auto	psy	prior to	utopsy findings available completion of cause of
teco The law are has	omp									perfo 1 ✓ Yes	ormed?	death? 1 ✔ Ye	es 2 No
tal Rec tian: The certificate	Be C	25. Was case referred examiner?						e of Death (					
F Vit Physic r this c	To E	1 <b>Y</b> Yes 2		Hospital: 1 1	Inpatient 2	ER/Outpatier		Other at Work?		Home 5	Residence how injury or		r. Scene
Division of Vital Records, tal or Attending Physician: The law requir is after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	ion:	27. Manner of Death  1 Natural	5 Pending	(Month	i, Day,Year)		1	Yes 2 X		nknown	Thorry Injury G	bouriou	
IVISION or Attendather death Director:	icat	2 Accident	Investigat	IOII	/31/2007 ce of Injury - At h	Fnd 12:	eet, factory, office	building, etc	. 2	8f. Location			ural Route Number, City
Divisior Hospital or Attend 24 hours after death - Funeral Director: stely filled in by the	Certification:	3 Suicide 6 4 Homicide	determine	ed (Specify)	found	in resid	ence			20 Wood	State) Rd. Abe	erdeen,	MD
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires, that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifier one) 2 M	ertifying Physic	ian: To the bes	st of my knowled	dge, death occi and/or investig	urred at the time, o ation, in my opinio	late and place n, death occ	e, and durred at t	ue to the cau	use(s) and ma	anner as stat	ed re cause(s)
To the within To the comple	Medical	29b. Signature and titl		and manner s	stated.		29c. Licen						onth, Day, Year)
		Can	00	419	la	U	O.C	M.E.			Februa	ry 1, 200	7
		30 Name and addres					Strock Dalkins	ore MAD	21204		J		
	la de	Carol Allan, N		ant Medical	Examiner distrar's Signa		Street, Baltim		Z 1ZU l				
S Regis	tate trar	<i>F</i>	EB 0 6	2007	Signer.	H A	186						

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12:15 PM Physician 30 2007 January Mary Lou Muir /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Allegany Lonaconing Egle Nursing and Rehab Center 8. Date of Birth (Month, Day, Y Apr. 19 If Under 24 Hrs. 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 9<sup>Yea</sup>r) 1927 **Funeral** Months Days Hours 1□ M & F 212-24-0620 Maryland 79 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinat must be notified at XX Yes 2 □ No Lonaconing Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 16001 St. Marys Church Terrace 21539 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. In term 27 is marked other than "natural" or the any injury or other transmitted. ☐ Yes 2 🔀 No f Yes, Give 1 Never Married 200 Married Specify: White Saltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housework Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Robertson Rhoda K. Donald ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16001 St. Marys Church Terrace, Lonaconing MD 21539 Amel Muir/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/02/ Cumberland Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Boal Funeral Home ansi 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 6 months Examiner Examiner ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐No ģ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No I or Attending Physicien: The after death.
Director: After this certificate I completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide e Hospital of 24 hours a Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the I within 2 To the F 29c. License number 29b. Signature and title of c 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 20 Douglas Ave, Longaring, md 21539 Neulin mas 40 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 200 Registrar

			1- State Amended 8,1/	State of Marylan						00100		
			1- State Amended 8,1/ Registrar	23/07,LDB,DOR	Ce	ertificate of	Death	Re	eg. No.	03429		
	Physici	an	1. Decedent's Name (First, Middle, La					Date of Deat Month	Day Yeer	3. Time of Death		
W	/Medic	Medical James A. McAllister, Jr.					or Location of Death	Jan. 1	17, 2007 3:40 p			
	Examin	ier	212 Choptank Av				mbridge			nester		
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs.	last birthda		If Under 24 Hrs.	8. Date of Birth (Month, Day,				
H	Director		220-30-0307	<b>10</b> /M 2□F 80	Yrs.	Months Days	Hours Mill.	<del>Jan.</del> 23	, 1926 Mai	ryland		
17215-0036 within 72 hours effer death with the Maryland ene. than "naturel; or flems 23s or 28s-1 show he Madical Examinar must be notified at	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or I	Location				10d. Inside City Limits		
	Mary	tor	Maryland Dorches	ter		Cambr	idge			1 des 2 □ No		
)	or 28	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	•		
	a 23a		212 Choptank Ave	NUE 12. Was Decedent Ever in U	6 40		21613	and the Van and Na	14. Race - Am	USA		
	fter de rittem	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?	.5. 13	/	Hispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Wh			
2-003p	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White		
<u>ئ</u>	"natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of working			16b. Kind of Busines:	s/Industry		
2	within ene. than	Jung	Elementary/Secondary (0-12)	College (1-4or 5+)		. DO NOT use retire stant Reg	o, ister of V	Jills	County Gov	vernment		
0	be filed Ital Hygi of other event, I	BeC							First, Middle, Maiden Sumame)			
Maryland	\$ 5 5 7 V	To B	James A. McAllis	,			Agnes	nes Phelps				
lan,	2 sho i and i m		19a. Informant's Name/Relationship (	Type, Print) Nephew						Town, State, Zip Code)		
	s 1 and 2 should if Health and Mer item 27 ie marke other traumatic	4.0	Mr. William W. Mc	20b. F	lace of Disi	position (Name of	St., Cambi		ID ZIOI3  20c. Location - City o	r Town, State		
altimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	emetery, cr	ematory or other pla	yard 1/23,		Cambrid e			
	permit. Page Depertment of Important: If eny injury or 20028.		21. Signature of Funeral Service Lice		100	22. Name and Addre	ess of Facility	-31		, raty tand		
<u> </u>	28258		telle Horas		ll	308 High	omwell Fur St., Cambi	ridge, M	D <sup>e</sup> , 21613			
		- (	Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart a ure. List only one cause on each line.									
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Coron		Arter	y DI	sease		Onset and Death		
	Examiner			Due to (or as a conseq	uence of)							
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury									
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (es es e conse								
60	death certificate be executed e attending physicien and id for use as the burial-transit	alE		Due to (or as a conseq	uerica or).							
89	ificate g phys as the			_ d.		THE STATE OF THE S						
Rox	th cert endin	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v		23d. Date of de			
E	e deal the att hed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d		Other (specify)				Month Day Year		
J.	law requires that the de as been signed by the a 2 should be detached	, Ph	Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?		
Vital Records,	puires n sign uld be	d by							1 Yes 2 No 3 Probably			
<u>o</u>	aw rec as beer 2 shou	Completed						24a. Was a	n 24b. Were a	utopsy findings available		
ž	0 5 0	No.						autops perform	ned? death?	completion of cause of		
/Ita	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death					
	Physi this c	5	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
0	th. : After tuner	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ryat rk? ]Yes 2 □ No	28d. Describe how injury occurred						
Division of	or Attending Physician: Ifter death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, s	street, factory, office			Location (Street and Number or Rural Route Number, City or Town, State)			
5	Ital or ors after red Dist			ballouring, otc. (opeon					. 51416/			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medicai		nysician: To the best of my knominer: On the basis of examina and manner stated.								
	Nithin Fo the	Me	29b. Signature and title of certifier			29c. Licen:	se number	25	9d. Date signed (Mon	ith, Day, Year)		
)	U		Brother miD D 5706					0 , 01/18/2007				
			30. Name and address of person who	completed cause of death (Item	A	- (+	Cambai	1	ml ai	1013		
	Sta	to	Brendon (a) 31. Date filed (Month, Day, Year)	32. Registrar's Signa		ova si.	Carner	age v	· U · 21	0/3		
	518	ne :	IAN 9 9	2007	La	1.1.						

07-00757

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Matthew Eugene Mitchell

, acci	cw Logon		1- For State Registrar	Ce	ertificate of		a wentan riye	Reg.	No. 00	07 00101	
	Physici	an/	Decedent's Name (First, Middle,Last)	F	Mit al al	7		Date of Death Month	ay Year	β. Time of Death : 0 0142 hrs	
Medi	cal Exami	ner	4a. Facility Name (if not institution, give	Eugene	Mitchel	b. City, Town, or I		Month D January 27,	2007 4c. County of E		
			Laurel Regional Hospital	otroot and manuscry		Laurel			Prince Geo		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8 Date of Birth(	MM/906/37YY) 5	oreign Germany	
	Director			M 2 F 43	Yrs.	Months	A TIGUIS AMILE	Decembe	r 25	Country	
	any		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Locati	on				10d Inside City Limits	
		ř	MD Prince Ge	eorges I	Laurel					1 X Yes 2 No	
	daryla 28a-f: Jaton	Director	10e. Street and Number			10f. Zip Code		10g	Citizen of What	Country?	
	h the day	Ö	3436 Andrew Court			2072			USA		
	ath wit items 2	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Ever in I Armed Forces?			panic Origin? ( Spec , Mexican, Puerto Ri		14. Race - A White, e	American Indian, Black, etc.	
	fter de [", or i		3 Widowed 4 Divorced	1 X Yes 2 No f Yes, Give Year or Dates:	1	Yes 2 No	specify:		Specify. B	lack	
	ours a	d by	15. Decedent's Education (Specify only	y highest grade completed)	16a. Deceden	's Usual Occupations of working life.	ion (Give kind of wor DO NOT use retired	rk done 1	6b. Kind of Busin	ess/Industry	
5	56 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		ouse Worl		,	Priva	ite	
3	d with ygiene	)om	17. Father's Name (First, Middle, Last)		1		18.Mother's Name (F	rst, Middle, Ma	iden Surname)		
į	21215-UU36 21215-UU36 Duld be filed within 7 Mental Hygiene marked other than ic event, the Medica	Be	Jack Mitch				Annette		Brown		
3	D 21 Should and Me ' is ma	Tol	19a. Informant's Name/Relationship (Typ. Janice Mitchell/W				tand Number or Ru ourt #202				
7	and 2 lealth 2 tem 27 traum		20a. Method of Disposition	20b	. Place of Dispos	tion (Name of cer				ity or Town, State	
	Baltimore, MD 21215-U036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Innportant: I fitem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3	Removal from State La	crematory or oth	<sup>ner place)</sup> Memorial	. Cem2/01/	2007	Fayettv	ille, NC	
	altin mit P partme portan ury or		Donation 5 Other Specify:     Signature of Funeral Service License	ge 1	22. N	ame and Address	of Facility John	nson & .	Jenkins	Funeral Home	
			Delha 44	Seretu			y St. NW			20011	
	Physician /Medical Examiner		23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Death  Death								
6			Immediate Cause (Final disease a. or condition resulting in death)	ACUTE SUBARACION  ue to (or as a consequence	old nenori	nage due t m	to ruptured	cerebral	artery		
		L	Sequentially list conditions, b								
		nine	if any, leading to immediate D cause. Enter Underlying Cause (Disease or injury that initiated c.	lue to (or as a consequence	ot):						
	ed nsit	Examiner	events resulting in death) Last	ue to (or as a consequence	of):						
	68760, certificate be executed nding physician and se as the burial - transit		dd	AMENDED O		/o /o= m					
	760, icate be physici the buri	Medical	IF FEMALE:	AMENDED #23a.27.permE	. G805, 3/	2/0/ TT	······	-	23d. Date of de	livery	
	687 certific ding p	cian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of	do oth	tal death 3	Ectopic pregnand	су	Month	Day Year	
	Box 687  he death certific  the attending pled for use as the	·E	1 Yes 2 No 9 Unknown	9 Unknown	5 Ot	her (Specify)					
	P.O. es that the igned by t	by Phy	Part II. Other significant conditions	contributing to death but no	t resulting in the i	ınderlying cause ç	given in Part I			Probably 4 Unknown	
	S, P quires t en sign ald be c							24a. Was an		ere autopsy findings available	
	cords law requir has been	Completed						autopsy perform	prid ed? dea	or to completion of cause of ath?	
	Re( : The ificate r, page	S	25. Was case referred to medical			26 Place	of Death (Check or	1 Yes 2	No 1	Yes 2 No	
	/ital /sician nis cert directo	o Be		ospital: 1 Inpatient 2	✓ ER/Outpatient		Other		esidence 6	Other:	
	ing Physician: The law requires that the figure this certificate has been signed by uneral director, page 2 should be detach to the control of the control o	n: T	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of			28d Describe ho	w injury occurred		
	sion death. ctor:	atio	1 Natural 5 Pending 2 Accident Investigation	n	<u> </u>		Yes 2 No				
7	Divis al or A s after al Dire	Certification:	3 Suicide 6 Could not be determined		home, farm, stre	et, ractory, office b	building, etc.	or Town, Sta		or Rural Route Number, City	
1	Division of Vital Records, e Hospital or Attending Physician: The law require 24 hours after death. Funeral Director: After this certificate has been si etcly filled in by the funeral director, page 2 should b	20 1	4 Homicide  29a. Certifier 1 Certifying Physicia	an: To the best of my knowle	edge, death occu	red at the time, da	ate and place, and d	lue to the cause	s) and manner a	s stated.	
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	one) 2 Medical Examiner:	On the basis of examination and manner stated	and/or investiga			the time, date ar	nd place, and due	e to the cause(s)	
	->=0	Ž	29b. Signature and title of certifier	m		29c. Licens O.C.				(Month, Day, Year)	
			m	ompleted extract that the	om 225\	0.0.	1∀1. ⊑.		January 27,	2007	
R			30. Name and address of person who could be a Ling Li, MD Assistant Me			et, Baltimore,	MD 21201				
		tate	4 0007	32. Registrar's Sign	ature de la la la la la la la la la la la la la	,			-		
	Regi	stra	FEB 01 2007	Daven D.	Marie						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-3. Time of Death Decedent's Name (First, Middle, Last) 2 Date of Death 200 Month Physician OI UV M MURAN JR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 N 2 F 052-12-4403 86 1920 New York 19. Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 📉 No Anne Arundel Annapolis Directo MD death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21401 1207 River Crescent Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or iten any or other traumatic event, the Medical Examiner. <sup>2□No</sup> 1944 1 ☐ Never Married 2 ☑ Married 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Addiction/Rehabilitation Counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Butler Peter Joseph Moran ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health as Important: If Item 27 Is any Injury or other trau 1207 River Crescent Drive Annapolis, MD. 21401 Betty Moran (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition January 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility Advent Funeral & Cremation Service 21. Stature of Fulleral service Licenses VE CXVV M00982 42 Hudson St., Suite 110, Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on sight line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arnen 3 Physician /Medical **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Unpatient 1 ☐ Yes 2 🖟 No 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the reception within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

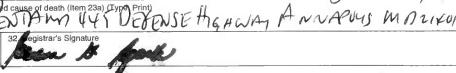
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) 1

Name and address of person



of death (Item 23a) (Type

200

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Maryland	Department of Healt	h and Mei	ntal Hygien	9007	00122	
		_	State Registrar		Certificate of Dea		Reg. N	6-001	03432	
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last	" Messick		2.	Date of Death Month Da	y Year	3. Time of Death  2. 35 a M	
	Examin		4a. Facility Name (If not institution, give Anne Arunde	street and number)	1 ten Anna P	ion of Death		nne f	Arundel	
	Funeral		5. Social Security Number 6. S		birthday) If Under 1 Year If Un Months Days Hou	rs Min.	Date of Birth (Month, Day, Year	9 Birth	nplace (State or Foreign untry)	
	Director		Usual Residence of Decedent	100 City T	own or Location	)	1-7-0		10d. Inside City Limits	
	Marylar 1-f ehov	tor	MD Queen	Anne's Ch	ester town	$\cap$			1 ☐ Yes 2 🔀 No	
	72 hours after death with the Maryland natural; or Itama 23a or 28a-f ehow Jical Examiner must be notified at	Director	10e. Street and Number 230 Devon	Daire	10f. Zip Code 2 1 6	20	10g. C	itizen of What Cor	untry?	
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Specifican Puerto Bio	y Yes or No-	14. Race - Amer Black, White		
36	irs after it, or its	by Fu	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 M No Spec		,	Specify: W	hite	
2-00	"natural",		15. Oecedent's Ec (Specify only highest gra	flucation 1 de completed)	6a. Decedent's Usual Occupation (Give kind of work done during t	most of working	16b.	Kind of Business/I	ndustry	
21215-0036	withir	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	*life. DO NOT use retired)  N A		Total State of the	NA		
Maryland	ould be filed v Mental Hygie arked other l atto event, III	Be	17. Father's Name (First, Middle, Last) Michael Ant	thony Mess		lother's Name (F	First, Middle, Maide	1.	Messick	
aryl	d 2 should by and Menta 7 is marked traumatic even	10	19a. Informant's Name/Relationship (	Type, Print)	9b. Mailing Address (Street and Nu	·	) (	or Town, State, Z	(ip Code)	
	s 1 and 2 if Health item 27 i		Burbara Mess 20a. Method of Disposition		230 Devon	Dr. Cl	nesterto	DWD , N Location - City or		
mor	Se to T		1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Hemoval from State	e of Disposition (Name of etery, crematory or other place)  Crematory	1/17/2		ltimore,	100	
Baltimore,	permit. Pag Dep-rtment Important: I any injury o		21. Signature of Funeral Service Licer	nsee	22. Name and Address of F. Hardesty Fund 12 Ridgely Av	eral Hom	ne polis, M	D 21401		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I one cause on each line.					Approximate Interval Between Onset and Death	
ı			Immediate Cause (Final disease or condition resulting in death)	a. Extreme	ty			Iday		
	Examiner		Convention lies and divine	Oue to (or as a consequent	intraventar	in lac	hemo	er peace	1000	
	ed sit	niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury					3		
,	te be executed ysician and te burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as a consequen						
68760,	ficate by physic s the bi	edicai		d						
Box (	eath certificate be executed attending physician and for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal de	ath 3 ☐ Ectopic pregnancy			23d. Date of deli	ivery Day Year	
P.O. I	that the decided by the a	hysic	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown						
	8 20 8	۵	Part II. Other significant conditions of	contributing to death but not resulting	Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown				
Records,	e law require has been sign 2 should b	Completed					24a. Was an autopsy performed?	24b. Were au prior to death?	itopsy findings available completion of cause of	
Vital F		0	25. Was case referred to medical		Place of Death (6	1 Yes 2 XNo 1 Yes 2 No				
of Vi	Physician: rthis certific ral director.	To B	examiner? 1 ☐ Yes 2 🔀 No		Outpatient 3 DOA Other: 4	Nursing Home	5 Residence		cify)	
on o	fte fre	tion:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	tb. Time of Injury at Work?  M 1 □ Yes		d. Describe how inj	ury occurred		
Division	or Atten fler deal prector: in by the	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
u	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce			dge, death occurred at the time, dat a and/or investigation, in my opinion,					
	To the within :	Mec	29b. Signature and title of certifier	lo.	29c. License num	ber	29d. D	ate signed (Monti	h, Day, Year)	
			1 Sugar R	affer	H 42-	133	20	mary	10, 2007	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SUZane Kend Flaish 2001 Medical Pkwy Anapalis MD 6							2140			
	Sta Regist		31. Date filed (Month, Day, Year)	32. Fegistrar's Signatur	Angell )					
	negist	all	JAN 1 8	FOOT TOWN	19000					

lichael Ray Mac	1	State of Maryland /   - For State degistrar	Departme <i>Certifica</i>			Mental H	Re	eg. No. 200	7 03133
Physiciai Medical Examin		i. Decedent's Name (First, Middle,Last)  Michael Ray Macey					2. Date of Deal Month January 2	Day Year	3. Time of Death 0221 hrs
1		4a. Facility Name (if not institution, give street and number) 3648 Washington Blvd			City, Town, or Lo	ocation of Death		4c. County of Deat Baltimore Co	
Funeral Director		5. Social Security Number 220-68-6177 6. Sex 1 X M 2 F	In yrs. last birtho	-	f Under 1 Year Months Days	If Under 24Hrs Hours Mir		22,1957 Forei	
w any		Jsual Residence of Decedent 10a. State 10b. County 11 OH Portage	0c. City, Town o	r Location	oro.				10d Inside City Limits 1 Yes 2 X No
Maryland 28a-f show any d at once.	Director	10e. Street and Number	SCIE		Of, Zip Code		1	Og. Citizen of What Cou	
th the M. 23a or 23 potified		670 Tern Court			442			USA	
death wir	Funeral		ver in U.S.	If Yes,	specify Cuban, I	Mexican, Puerto	pecify Yes or No Rican, etc.)	White, etc.	ican Indian, 8lack, hite
urs after ttural", aminer	≥⊦	Widowed 4 Divorced of Page 14 Divorced of Page 2 Divorced of Dates:  15. Decedent's Education (Specify only highest grade comp		ecedent's	s 2 X No Usual Occupatio	n (Give kind of		Specify:  16b. Kind of Business	
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-fah or other traumatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	) dı	U	of working life. [ Instal]		ired)	SLS Serv	ices
MD 21215-0036 at 2 should be filed within 7 th and Mental Hygiene n 27 is marked other than umatic event, the Medica	Be Cor	17. Father's Name (First, Middle, Last) Albert G. Macey			18		e (First, Middle, M V. Colli	Maiden Surname)	
C = 2 = 3		19a. Informant's Name/Relationship (Type, Print )  McArthur Macey/Brother	19b.		dress (Street a			nber, City or Town, State erna Park,	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is rr	f	20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State		Dispositio	n (Name of ceme	etery, Ja	n. 29,	20c. Location - City of	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If itel mijury or other tr	1	4 Donation 5 Other Specify: 21. Signature of Puneral Service Licensee	oren	22 Nam	e and Address o	of Eacility	2007		
M ឱ្យី១១ Physician	-	23a Pan I. Enter the disease, or complications that caused the	ne death. Do not		anco & Ritchie				Funeral Home MD 21146  Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)		ntoxic	ation				8etween Onset and Death
1		Sequentially list conditions, b.							<u> </u>
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last							
60, ate be executed hysician and e burial - transit		d_							
'60, zate be ev physician he burial	Medic	IF FEMALE:  AMENDED  AMENDED  AMENDED  23c. If yes, outcome			4, 2/12/07	7 TT		23d. Date of deliver	у
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	me of death 5	Fetal Other	death 3 (Specify)	Ectopic pregn	ancy	Month	Day Year
P.O. Bc that the deened by the a	•	Part II. Other significant conditions contributing to death	out not resulting	in the und	erlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ords, P.	ted by	***			•		1 Yes	an 24b. Were a	bably 4  Unknown utopsy findings available
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack	Completed						autop perfo 1 <b>✓</b> Yes	rmed? death?	completion of cause of es 2 No
/ital Revysician: The	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatien	2 FR/Ou	tpatient 3		of Death (Check		Residence 6 🗸 Othe	er: Scene
n of V ding Phy After thi funeral d	٦: To	27 Manner of Death 28a. Date of Injury (Month, Day, Yes		ime of Inju	y 28c. Injury	at Work?	28d. Describe	now injury occurred	
VISION OF Attence ter death birector:	Certification:	2 Accident Investigation Find 1/24/2 3 Suicide 6 X Could not be	ry - At home, far	2:12 a	em	es 2 X No			ural Route Number, City
Divis  Hospital or A 4 hours after Tuneral Dire		4 Homicide determined (Specify) NC 29a Certifier Certifier Physician To the best of my	otel 	th occurred	at the time date	e and place an			ngton Blyd. Rm
To the Ho within 24 h To the Fu	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated				death occurred		and place, and due to the	ne cause(s)
	2	29b. Signature and title of certifier  Linear L. Hoy Hay M., m.,			O.C.N			January 24, 200	
		30. Name and address of person who completed cause of de Pamela E. Southall, MD Assistant Medic		111	Penn Street,	Baltimore	MD 21201	L	
	ate		s Signature	0					
Regist	rar	2. 3. 4	Stand Stand	See Land	the s				

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Joseph G. Neomany  $A^{M}$ January 20, 2007 /Medical 10:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Annapolitan Assisted Living Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) April 11, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days Months **½** 2 □ F 030-12-7423 79 Massachusetts Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Anne Arundel 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified. Director Maryland Annapolis 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1514 Shipsview Road 21409 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give
Year or Dates: 1945–46 1 ☐ Never Married 2 TMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify. Specify: White <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Manager Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Neomany Julia Gapa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Neomany/wife 1514 Shipsview Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2/Coremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 1/23/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Toda 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner bunal-tran Due to (or as a consequence of): Records, P.O. Box 68760 the attending physician Physician/Medical as the t IE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Living Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Facility 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this e Hospital or Attending Ph 24 hours after death. e Funeral Director; After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063145 Jan. 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5×1 Arvind Desai 115 Roesler Road Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of N	Maryland		artment of I			•	_	00	0.7	031.35
			Registrar  1. Decedent's Name (First, Middle, Lateral Control of the Control of t	st)			incate or	Death		2. Date of De	Reg. No.	<u> </u>	4.1.	3. Time of Death
	Physici		-	Kaye	Nicho	laon				Month JAN	Day		Year 1007	1245 M
p	/Medic Examir		4a. Fecility Name (If not institution, give			TSOIL	4b. City, Town,	or Location	ot Death	3/7/0	_	County		1213
	LXUIIII		leginsula legina	al medic	1/10	Apr	50/	ishu	11			Wir	omic	6
	Funeral		5. Social Security Number 6. S		Age (In yrs. la	st birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bin (Month, Da	th v. Year)	70,70		ace (State or Foreign
ı.	Director		210-40-3713	□ M 2 🗙 F	64	Yrs.	Worten's Day's	110013		10/26		2		yland
	pur *		Usuel Residence of Decedent  10a. State 10b. County		10c, City.	Town or Lo	ocation						10	Od. Inside City Limits
	Aaryli Paho Pat et	ō	Maryland Wicomi	CO.		alisbu								1 ☐XYes 2 ☐ No
	28s-	Director	10e. Street and Number		56	ITISDU	10f. Zip Code				10a. Citi	izen of W	hat Coun	trv?
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. itsm 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svant, the Medical Examiner must be routified at		404 I Moss Hil	l Lane			21	.804			_	USA		•
	ms 2	Funerai	11. Marital Status	12. Was Deceder		. 13.	Was Decedent of	Hispanic Or	igin? (Spe	cify Yes or No	-			an Indian,
9	or Ite	Ţ	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2 1 If Yes, Give			If Yes, specify Cut 1 ☐ Yes 2 <b>X</b> No			Hican, etc.)			c, White, e	
93	iral',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates	<b>5</b> :		10 105 201110	Specify.				Specify:		white
21215-0036	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece (Give	dent's Usuat Occu kind of work done DO NOT use retire	pation during mos	st of worki	ng	16b. Ki	ind of Bus	siness/Ind	ustry
121	within ne. han	mp	Elementary/Secondary (0-12)	Coltege (1-40	r 5+)			ea)			_	_		
2	Hygie ther int.		12 17. Father's Name (First, Middle, Last)	_		Cook		18. Moth	er's Name	(First, Middle,			ervi	ce
an	nould be filed within Mental Hygiene. Narked other than	To Be	Raymond A. Hopk							irgini				
Maryland	2 should and Men is marke sumatic	۳	19a. Informant's Name/Relationship (	Type, Print)		19b. Maili	ng Address (Stree	t and Numb	er or Rura	l Route Numbe	er, City o	r Town, S	State, Zip	Code)
	and 2 balth a n 27 ls		Mark E. Nicholson	/son		404	I Moss H	ill L	ane,	Salisb	ury,	MD	21804	1
re,	itsm 27		20a. Method of Disposition		COL	nce of Dispo	sition (Name of matory or other pla	ace)	D	ate	20c. Lc	ocation - (	City or To	wn, State
E	Page net o int: If Iry or		1 X Burial 2 ☐ Cremation 3 ☐  * 4 ☐ Donetion 5 ☐ Other (Specify			_	emetery		1/25	/07	Hek	oron,	MD	
Baltimore,	permit. Pages 1 and Department of Health Important: If itsm 27 any injury or other tr once.	-	Signature of Funeral Service Licer	1500		Ě	Name and Addr	Funer	ăl Ho	me Pro	fess	iona	l_Ass	ociation
_	89 = 9		David H. Qo	moscom	CFS	P 5	OI Snow	HITT	Rd.,	Sālisbi	ury,	MD .	21802	1
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the deeth. line.	Do not ent	er the mode of dy	ing, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
Mary I	Physician		Immediate Cause (Final disease or condition	, Colo	12 00	-for	roting	1						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a conseque	ence ot):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							•
	LAdifilite	_	Sequentially list conditions,	b										
	be asi	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10) 01 800	as a conseque	erice or):								
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a conseque	ence of):			-					····
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E		d										
89	ficate g phys	edic		· · · · · · · · · · · · · · · · · · ·										
Вох	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnan		75					23d. Date	of delive	ту
	the atte	icia	in the past 12 months?		at time of dea		<pre>JEctopic pregnance Other (specify) _</pre>	;y 				Mon	th	Day Year
P.0	that the ded by the detached	Physician/Me	9 ☐ Unknown											
	signed to det		Part II. Other significant conditions of	ontributing to death	but not result	ting in the u	nderlying cause gi	ven in Part I	l.					e cause of death?
ord	w requir been si should	ted	maloutrit	200						1 4	Pes 2	∐ No	3 Proba	ably 4 □Unknown
Records,	law law las b	Completed by	Chanic ob	struc	Lue	PIL	monary	dis	au	24a. Was	SY	_ pi	for to con	sy findings available appletion of cause of
<u>=</u>		Co								perfo 1 ☐ Yes	rmed? 2 No	de	eath?	2 <del>□</del> No
Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case reterred to medical examiner?	Hospital:			0.		e of Death	(Check only o	ие)			
of	Phys this al dir	. To	1 Yes 2 No  27. Manner of Death	1 LUmpa		R/Outpatier 28b. Time o	IL SEL DON			ne 5 Resident				)
O	ding P. h. After funer	Certification:	1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I	Day Year)	Injury	Wo	ork? ]Yes 2 □		EDO. DESCRIDE I	iow injui	y occurre	io .	
Division	I or Attendi after death. Director: A I in by the fu	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of	Injury - At hon	ne, tarm, str	eet, tactory, office			28f. Location (S	Street an	d Numbe	r or Rural	Route Number,
Div	after Dirac	erti	4  Homicide determined	building,	etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tov	vn, State	)		
	spite hours inera y filte		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my know	ledge, deat	h occurred at the t	ime, date ar	nd place, a	and due to the	cause(s)	and man	ner as sta	ited.
	To the Hospital or Attanding Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one)	niner: On the basis and manner	stated.	on and/or in	vestigation, in my	opinion, dea	ath occurr	ed at the time,	date and	place, a	nd due to	the cause(s)
	To t To t	Σ	29b. Signature and titte of certifier				29c. Licen	se number			29d. Dat	e signed	(Month, E	Day, Year)
	100		, ( ) T				1/50	6043			1	27	20	57
	170		30. Name and address of person who				Print)	hilal	Mn	2180	1			
	۲ ,		31. Date filed (Month, Day, Year)	5'(e) //V	trar's Signatu		3443	oury	7119	2180	//			
		ite		32.1100	and a congrission	-								

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

#### 07-00705

Kevin M. Newman, Jr.	State of Maryland / Department of Heal	14
	State of Maryland / Department of Heal	11

evin M. Newma	an,	1- For State		Health and			Jible.	
Physicia	an/	Registrar  1. Decedent's Name (First, Middle,Last)	inicate of L	<del></del>		Re 2. Date of Deat	g. No.	3. Time of Death:
Medical Exami		,	T			Month	Day Year	0817 hrs
		Kevin M Newman  4a. Facility Name (if not institution, give street and number)	JF. 4b	City, Town, or I	Location of Deat	January 25	4c County of Deati	
		Southern Maryland Hospital Center		Clinton			Prince George	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, Ia	ast birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Birt	h(MM/DD/YYYY) 9. Bir	
Director			· · · · ·	Months Days		1	Foreig	n Maryland
		217-29-6502   1 XM 2 F   16	Yrs.			June	23 1990 👓	untry) =
any			Town or Location					10d. Inside City Limits
d how ;	_	Manual and Durings Coopers Duri						1 X Yes 2 No
Maryland 28a-f show any d at once.	cto	Maryland Prince George Bra	andywin	Of. Zip Code		140	g. Citizen of What Cou	**
oith the Maryland 23a or 28a-f shov	Director			·		10	g. Gilizen di what Coul	TUY?
ith th		15516 Brandywine Road  11. Marital Status  12. Was Decedent Ever in U.		20613	3		USA	
ath w	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes,	specify Cuban,	panic Origin? ( S , Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
er de	교	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year					D1-	-1-
hours afte 'natural'', Examiner	þ	15. Decedent's Education (Specify only highest grade completed)		es 2X No		<del> </del>	Specify Bla	
2 hours at "natural	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's during most		on (Give kind of DO NOT use ret		16b. Kind of Business/I	ndustry
36 iin 72 han dical	ple	8						
15-0036 filed within 72 Hygiene. d other than ", the Medical.	om	17. Father's Name (First, Middle, Last)		tudent			High Sc	hool
215- be filed ntal Hy, rked of	C					e (First, Middle, M	aiden Surname)	
21214 ould be fill Mental F marked c event, t	o Be	Kevin M Ne  19a. Informant's Name/Relationship (Type, Print)	wman Sr	ddrono (Charat	Diane		Na	than
C of B is it	-	Kevin Newman Sr./ Father	115516	Drand.	and Number of	Rurai Route Numi	per, City or Town, State	Zip Cod 20613
e, ML I and 2 sl Health ar item 27			Place of Dispositio				dywine, Ma 20c. Location - City or	
Ore ges 1 of H If i			rematory or other		,	Balo	200, Education - City of	TOWII, State
Pass ment tant:		4 Donation 5 Qther Specify: Re	surrect	ion	2/	1/2007	Clinton,	Maryland
Baltimore, permit Pages I ar Department of Hee Important: If ite		21. Signature of granal artice Licenses	22. Nam	ne and Address	of Facility A	lams Fu	neral Hom	e PA
	_	23a. Part I. Emer i.e. //sease, or copyrications that caused the death.	206	05 Aqı	uasco F	d Aqua	sco, Maryl	and 20608
Physician		23a. Part I. Enter et isease, or complications that caused the death. failure, List only one cause or each line.	Do not enter the	mode of dying, s	such as cardiac o	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cau (Final disease a. Dilated cardiomy	opathy					Death
		or condition resulting in death)  Due to (or as a consequence of	):					
7-0-	_	Sequentially list conditions, b.						
	Ē.	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	):					
	Examiner	(Uiscase or injury that initiated events resulting in death) Last  Due to (or as a consequence of	):	-				
cuted	Ŵ	d						
be executed sician and urial - transi	dical	X UNPENDED AMENDED C -065	2/12/07 7	<del></del>				
	ĕ	IF FEWALE. 23c. If yes, outcome of pregn	ancy	3/12/07 T	1		23d. Date of delivery	
68760 certificate b nding physi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 Fetal	death 3	Ectopic pregna	ancy		ay Year
Box (e death co	Sici	4 Pregnant at time of dea	ath 5 Other	(Specify)			ļ	
hed hed <b>a</b>	اغ	9 UNKNOWN						
F.O. E	þ	Part II. Other significant conditions contributing to death but not re	suiting in the unde	eriying cause giv	ven in Part I.		acco use contribute to t	per m
		Seizure disorder; autism				1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
of Vital Records, ag Physician: The law requir the this certificate has been smeral director, page 2 should la	Completed					24a. Was ar autops		opsy findings available impletion of cause of
tal Reco	E					perform	ed? death?	_
rtific tor, p		25. Was case referred to medical		26.Place o	of Death (Check		No 1 Ye	s 2 No
n of Vital   nding Physician: th :: After this certifi e funeral director,	o Be	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 V	ER/Outpatient 3		Ther -		esidence 6 Other:	
ing Phy After th	<b>—</b> 1	27. Manner of Death 28a. Date of Injury	28b. Time of Injur				w injury occurred	_
	힐	1 X Natural 5 Pending (Month, Day, Year)		1 Ye	es 2 No		,,	
Division Is after death al Director: /	<u>ig</u>	2 Accident Investigation 28e. Place of Injury - At hor	me farm street f	actory office bu	ilding etc	28f Location (Str	eet and Number or Rur	al Bauta Number City
Div tal or rs aft	Certification:	determined (Specify)	,,,	actory, emoc ba	mung, etc.	or Town, Sta		al Route Number, City
lospi 4 hou uner ily fil		200 Certifier		-14-15-15-11-1				
Divi	S	(Check only one) 2 Medical Examiner: On the best of my knowledge one)	e, death occurred	at the time, date , in my opinion, o	e and place, and death occurred a	due to the causer of the time date ar	s) and manner as state	d.
To CON	Medical	and manner stated 29b Signature and title of certifier		29c. License			29d Date signed (Mon	
		On all		O.C.M				
		uness		J	··-·		January 26, 2007 	
	1	<ol> <li>Name and address of person who completed cause of death (Item 2 Ana Rubio MD. Assistant Medical Examiner 1</li> </ol>		ot Poltime	o MD 24204			
120			11 Penn Stre	et, Daitimon	e' IAID 5150.			
St: Regist	ate rar	31. Date filed (Month, Ray Year) 1 2007 32. Egistrar's Signatur	* Some	E.				

			1 - For State Registrar	State of M	aryland .			f Health : of Death			giene Reg. No.	007	034	37
	Physic		1. Decedent's Name (First, Middle, La. PERCY A. PLUMMET	·						2. Date of Dea	ath 10ay	2007	3. Time of 4:21	Death A M
	/Medi Examir		4a. Fecility Name (If not institution, given ARCOLA HEALTH & RI			NTER		m, or Location			4c. (	County of Dea	ath	
	Funeral Director		5. Social Security Number 6. S 262-38-6767 1  Usuel Residence of Decedent	ex 7. A( ☐M 2☐F	ge (In yrs. last 86	birthday) Yrs.	If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birth Month, Day 1 / 1 4 / 1 9		9 Bi	rthplace (State of country) TOIT MI	r Foreig
	the Maryland 28e-f show	Director	10a. State 10b. County MD Prince Go	eorge's	10c. City, To		Hills						10d. Inside Cit	,
	oud be lied within 7.2 hours after death with the Maryland Mental Hygiene. artice of the rhan "natural", or items 23a or 28e-f show tatice event, the Medical Examinat must be motified at	by Funeral	6705 Dorman Stree  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 MYes 2 If Yes, Give Year or Dates:	No	6a. Deced	Yes 2 X	8 4 of Hispanic Ori cuban, Mexicar No Specify:		cify Yes or No- Rican, etc.)	U. 14	SA  4. Race - Am Black, Whi Specify: B1	erican Indian, te, etc. ack	
	be riled within / htal Hygiene. ed other than "n event, the Media	Be Completed	(Specify only highest gra  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	College (1-4or	5+)	(Give . life. L	ind of work do NOT use re improver Unk	ne during mos tired) nent 18. Mothe	er's Name	(First, Middle,	Priva Maiden S	ate	· · · · · · · · · · · · · · · · · · ·	
	fealth and sm 27 is m	To	19a. Informant's Name/Relationship (7)  James J. Plummer  20a. Method of Disposition  1 Burial 2 Cremation 3 □	- Son	20b. Place	705 D of Dispos of Oren	orman S sition (Name of eatory or other)	eet and Numbe St. Lan	dove	lenderson Route Number Hills	r, City or		20784	
	Defilit. rages Department of h Important: If ite any injury or of		*4 □Donation 5 ▼Other (Specify  21. Signature of Funeral Service Licen	inument Nava	Arlin	1gton 22 26	Name and Ad 17 Penr	dress of Facilit	SE W	oe Fune: Vaching	ral H ton I	agton V Home OC 2002		
	hysician and hysician and hysician structures the private transit	edicai Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRA Due to (or as b. PNEUMON Due to (or as	TORY 1	FATLUSE of):		tying, such as	cardiac or	respiratory arr	est,		Approximate Interval Betw Onset and Do	veen
the dead the other	y the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnal Other <i>(specify)</i>				230	d. Date of del Month		ear
baw roonings that the	been signed by the	by	Part If. Other significant conditions co	ntributing to death b	ut not resulting	j in the un	derlying cause	given in Part I.					the cause of decorate	
The	ate has	Be Completed	25. Was case referred to medical					26 Place	of Death	24a. Was an autops perform 1 Yes 2	No	death?	itopsy findings av completion of cau	vailable use of
To the Hospital or Attending Physician:	ector: After this by the funeral di	Certification; To E	examiner?  1 Yes 2 No  27. Manner of Death  1 Notural 5 Pending investigation  3 Suicide 6 Could not be determined	dospital: 1 ☐ Inpatie  28a. Date of Injun (Month, Day)  28e. Place of fnjun building, etc	y Year) 28b	Time of Injury	28c. In W	Other:    top   top	sing Homo 28	e 5 ☐ Reside	nce 6 [ w injury o	ccurred	cify) eral Route Numbe	er,
Hospital	within 24 hours after To the Funerel Directory Completely filled in	edical Cer	29a. Certifier 11 Certifying Phy (Check only one) 2 Medicel Exemi	sician: To the best of ner: On the basis of and manner sta	of my knowledge	ne death	accurred at the	time date and	place, an	due to the ca	1150/0) 000	d manner as ace, and due	stated. to the cause(s)	
Tothe	within To the comple	Med	29b. Signature and title of certifier	Mp				nse number		29	d. Date s	igned (Month	n, Day, Year)	
	(6)		30 Name and address person who con Surekn K Gupta, 31 Date filed (Month, Day, Year)	MD 9001 G				te 220	Silv					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 1 2007 RICHARD WILBUR POMEROY 5:05 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 21 9. Birthplace (State or Foreign **Funeral** 1934 California Days Hours 1**X** M 2□ F 559-42-2455 Director 72 Aug Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wode in than "natural", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14078 Turners Point Rd. 21645 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XYes 2 No 1956 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: -1959 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Private School College (1-4or 5+) Elementary/Secondary (0-12) Groundskeeper/Janitor Pre-K or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) n and Mental h Emma Belle Sotier John Francis Pomeroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21645 14078 Turners Point Rd. Kennedyville, Health itam 27 i Sarah Jo Pomeroy (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or 2008. 4 □ Donation 5 □ Other (Specify) 2/3/07 Kennedyville, MD. Shrewsbury Cem. 21. Signature of Fun fal Service License Galena funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 L. Schaech 21635 M00510 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 46UTE /Medical Due to (or as a consequence of) ADDER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 Yes 2 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed of Vital 2 No 1 Yes Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 atural 5 Pending death. М 1 ☐ Yes 2 ☐ No. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by or A after 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) 113605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D.120 Speer Rd. Chestertown, MD. 21620 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

	Physici /Medic		LOIS ANNE PFLUGH				Month Da NUARY 21	
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, o	or Location of Death		. County of Death
			110 LANCASTER COU		ANNAPOL			NNE ARUNDEL
	Funeral		5. Social Security Number 6. S	□M 2NTE	thday) If Under 1 Year Months Days	Hours Min.	Date of Birth Month, Day, Year,	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	59	113.	AU	GUST 15,	1947 NEW JERSEY
	ehow		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene.  ed other then "natural", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	tor	MARYLAND ANNE ARI	INDEL ANNAPOL	.TS			1 ☐ Yes 2 🕱 No
	r 288	Director	10e. Street and Number		10f. Zip Code		10g. Ci	tizen of What Country?
	th wit	aiD	110 LANCASTER COUL	RT	21401		USA	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	Hispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No-	14. Race - American Indian, Black, White, etc.
98	or It	J.	1 Never Married 2 Married	1 ☐ Yes 2 👿 No If Yes, Give	1 ☐ Yes 2 X No		, ,	04
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				MULTE
15	n 72 nat	lete	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occur (Give kind of work done life. DO NOT use retire.	during most of working	16b. K	(ind of Business/Industry
21215-0036	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)  5+ EXF	CUTIVE VICE		FIN	ANCIAL SERVICES
0	filed Hygie other	BeC	17. Father's Name (First, Middle, Last)		OUTTVE VIOL	18. Mother's Name (Fit		
Maryland	2 should be and Mental Is marked o		ALBERT HENRY PFLUC	#H		CHARLOTTE	ADELE HOV	7 <b>T</b>
ary	should and Men a marke umatic	_	19a. Informant's Name/Relationship (		Mailing Address (Street			or Town, State, Zip Code)
	5 E Z =	li i	MARY D. GLASSPOOL	/EXECUTOR 920	OLD ANNAPO	OLIS NECK RO	AD, ANNAP	OLIS, MARYLAND 21403
Baltimore,	ges 1 ar t of Hea if Item? or other		20a. Method of Disposition	20b. Place of	Disposition (Name of y, crematory or other place	Date	20c. L	ocation - City or Town, State
Ë	Pages nent of int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	Memoral mont State	EAKE CREMAT	OTHIOTHE		ENSVILLE, MARYLAND
a <del>I</del>	그 된 문을		21. Signature of Funeral ervice Licer		22. Name and Addre	ass of Facility		
m	Depa Impo eny I	1	) (Jan)	1000	814 BESTGA	FENBELN,NEWI TE ROAD. AN	NAM CKEMA NAPOLIS.	TION ANDFUNERAL CARE MARYLAND 21401
			23a. Part1. Enter the disease, or com	plications that caused the death. Do rone cause on each line.				Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a consequence of				115 years
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	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
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9 ×	eath certific attending p	/Me	IF FEMALE:	22a Marca cuteoma of programme				
Вох	ath c	ian	23b. Was decedent pregnant in the past 10 ponths?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		/		23d. Date of delivery  Month Day Year
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σ.	The law requires that the ste has been signed by th page 2 should be detach	/ Phy	Part II. Dther significant conditions of	ontributing to death but not resulting in	the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	uires sign Id be	d by	Breast can	CPAC	, ,			No 3 Probably 4 Unknown
Ö	w require been si should b	ete					04- 146	7
Re	The lav sete has page 2	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
		e Co	25. Was case referred to medical				1□ Yes 2 No	
⋚	in sec	8	examiner?	Hospital:	nationt 3 DOA Oth	26. Place of Death (C)		
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á	al or A after I Direct d in by	ert	4  Homicide determined	building, etc. (Specify)			City or Town, State	a)
	Hospital or Attending 24 hours after death. Funerel Director: After itely filled in by the tune	- r	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge.	, death occurred at the tir	ne, date and place, and	due to the cause(s	) and manner as stated.
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical Exan	niner: On the basis of examination and and manner stated.	d/or investigation, in my o	pinion, death occurred a	t the time, date and	d place, and due to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier		29c. Licens	e number	29d. Da	te signed (Month, Day, Year)
			/ Kanine	weins, MD	DS	6820	Jun	vary 22, 2007
12	CM)		30. Name and address of person who	completed cause of death (Item 23a) (	Type, Print)	- 2		uary 22,2007 MD 2140/
-			Hanine Werner	MU, 900/3054at	e Road #	200 YUN	apolis.	MD 2140/
			31. Date filed (Month. Day, Year)	22 Monintrario Cigninatura			•	

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 4 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jan. Ž'007 10:20 A M 20, Joanne Christine Rozyczko /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Jan. 23, 1950 Detroit, Michigan 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours 1□ M 2X F Days 56 Director 212-54-6290 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ehow The Medical Examinar must be notified at No Yes 2 No Director Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 Yates Road 20705 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assembler 12 Industrial and Mental Hygi other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Arthur Henrick Christine Dorothy Niemiec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom J. Rozyczko – Husband 4700 Yates Road, Beltsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 1/25/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Service License 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition **Physician** Metastatic Breast Cancer 1 year resulting in death) /Medical Due to (or as a consequence of): Examiner Pleural Effusion I month Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Chronic Deep Vein Thrombosis 1 year attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Seizure Disorder Physician/Medical 5 years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 20 No director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Tes 2X No this After thi funeral o 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: , 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a
To the Funeral C
completely filled i the Hospital 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DD005510 30. Name an address of person who completed caus if death (Item 23a) (Type, Print) Balnath Bhandary, MD 7227-B Hanover Parkway, Greenbelt, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of	Marylan	•	artmen rtificate			and M	ental Hyg	iene eg. No:	007	-021	
	Physici	an	1. Decedent's Name (First, Middle, La	ist)							Date of Deal Month	h Cay	U U / Year	3. Time o	of Death
	/Medic		WILLIAM	RAI							JANUARY		2007	2:53	A M
-	Examir	ner	4a. Facility Name (If not institution, gi		oer)				Location o	of Death			unty of Dea		
-	Funeval	24	PRINCE GEORGE S  5. Social Security Number  6.		Age (In yrs.	last birthday)	If Under		Y If Under:		8. Date of Birth		9. Bi	Thplace (State	or Foreign
No.	Funeral Director			1 □ <b>X</b> M 2 □ F	66	Yrs.	Months	Days	Hours	Min.	(Month, Day JUNE 19		C	ountry) RGINIA	
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	Ne M	ecto	10e. Street and Number	EURGE 5		CAPII	10f. Zip		<u></u>			On Citizon	n of What C	11	
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036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow he Madigal Exemples must be multised at	by Funeral Director	941 ABEL AVENUE  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? X No	}			spanic Ori n, Mexican	gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	14.	S.A. Race - Am Black, Whi pecify: BI		<u> </u>
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212	y withir	m o	Elementary/Secondary (0-12)	College (1-4	for 5+)		TENAN					GOVE	ERNMEN	IT	
Maryland 2	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other than other traumatic event, the M	To Be C	17. Father's Name (First, Middle, Las HUGH HILL	1)							(First, Middle, RAINEY	Maiden Su	mame)		
	and 2 should I Balth and Men n 27 le marke ter traumatic		19a. Informant's Name/Relationship TREVA P. RAINEY	-							I Route Number L HEIGH				5
ore,		1	20a. Method of Disposition	7D	1 ~	Place of Dispo	sition (Name	ne of ther place	9)	D	ate	20c. Locat	tion - City o	r Town, State	
im	Pages nent of I ant: If Its ury or o		1 ⊠Burial 2 □ Cremation 3 ☐ 4 □ Donation 5 □ Other (Spec		MA	RYLANI	NAT:	ONAL						RYLAND	
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	ha (			2. Name an 7474 I				J. B. JI LANDOVI				
	Physician / Medical Examiner	Examiner	23a. Par1. Enter the dis-ase, or cor shock, or heart the ure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. VENT  Due to (o  Due to (o	r as a conseq	AR FIBF uence of):			g, such as	cardiac	respiratory arr	951,		Approxima Interval Be Onset and	etween
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Vital	ysiclan: The is certificate hadirector, page	0	25. Was case referred to medicat						26. Place	of Death	1 ☐ Yes (Check only or		1 🗆 10	s X No	
<u> </u>	Physical this cer al direc	To B	examiner? 1 ☐ Yes 2 → No	Hospital: 1 ☐ In	patient 21	ER/Outpatier	nt 3 DC	Othe	100		me 5 ☐ Resid		Other (Sp.	ecify)	
ion of	Jing P		27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigate		Injury Day Year)	28b. Time o Injury	f 2	28c. Injury Work 1 🗆 Y	at ?? /es 2 🗆		28d. Describe h	ow injury o	ccurred		
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	To the Hospitsi or Attent within 24 hours efter deati To the Funeral Director: completely filled in by the	Medical (	29a. Certifier 1	thysician: To the barriner: On the barriner and manner	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ie, date an pinion, dea	d place, a	and due to the c ed at the time, d	ause(s) an ate and pl	d manner a ace, and du	ts stated. le to the cause	(s)
	To the comp	Ž	29b. Signature and title of certifier			4	290	c. License	number		4	9d. Date s	igned (Mor	nth, Day, Year)	
				MD	1/27	107	M	D034	511		J	ANUAF	RY 23,	2007	
<u></u>	(15)		30. Name and address of person who TIMOTHY J. CH	RIMMINS M	.D. 2	150 PE		VANI	A AVI	ENUE	N.W. WA	SHING	GTON, D	C 2003	7
	Sta	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	1)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jannth 21 11 P **Physician** 2007 Richter Mildred Virginia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Solomons Calvert 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F Maryland 215-22-2711 94 Sept 4 1912 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland to Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12970 Spring Cove Drive 20657 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12th own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiant: If Item 27 is marked oth Be William Brenton Phillips Elizabeth Schenning ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Slingland- daughter 13409 Stowaway Ct. Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery Jan 26 2007 Baltimore Maryland 21. Signature of Funeral Service Licensee Rausch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, approximate approximate approximate approximate. Immediate Cause (Final Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or inJury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed 2 No 21 No 1 ☐ Yes 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ဥ 1 TYes 25 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1. Natural 5 | Pending Injury n 24 hours arred. The Funeral Director: Afficients of the funeral 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Hospital Dr. Scile 3/ 31. Date filed (Month, Day, 32. Registrans Signature Year) State 2007▶ 3 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10.0.7

			1 = For State Registrar	State of Maryland		nt of Health and Ite of Death	Mental Hygie		03443
	Physici	20	1. Decedent's Name (First, Middle, Last	, 0111	0.	0.0	2. Date of Death	Day Year	3. Time of Death
	/Medic		Deborah	HNN	KO	RR	01-1	8-07	11:07 AM
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	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. la	st birthday) If Unc	er 1 Year If Under 24 Hr			plece (State or Foreign
4	Director		OU O CON TEXAL	JM 24 50	Yrs. Month	s Days Hours Mir	8. Date of Birth (Month, Day, Ye	56 mar	rtry)
	and w		Usuel Residence of Decedent  10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits
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	r 28a	irec	10e. Street and Number	RSET 1		Tip Code		Citizen of What Cou	ntry?
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	er des	unei	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. Was Dec If Yes, sp	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc.
36	irs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give / Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	hite.
21215-0036	72 hou nature dical E	ted	15. Decedent's Edu	cation	16a. Decedent's Us	ual Occupation	16b	. Kind of Business/In	dustry
215	d within 72 ho jiene. r than "natur the Medical	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		work done during most of we use retired)	A1 6	TULLS	
121	il Hygier other th		17. Father's Name (First, Middle, Last)		Certitie	1			6 Home
anc	e la la la la la la la la la la la la la	To Be	Timothy SI	DNEY B	URGE	_	me (First, Middle, Maid +Y ANN		0 (
Maryland	2 shoul and Me le mark	Ĕ	19a. Informant's Name/Relationship (T)	una Oriati	405 14.25. 4.11	ss (Street and Number or R			
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ore	ges 1 it of He if item or oth	ı	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Pla	ice of Disposition (N	ame of other place)		Location - City or To	
Ë	Pa men ant: ury	9	' 4 □ Donation 5 □ Other (Specify)	Cron	natory of	Delmarva 1	22/07 D	elmar	DE
Baltimore,	permit. Departn Imports any injt		21. Signal of Funeral Service Licens			e Smith Fune	rol Home		nbella St ermd 2180
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the death. ne cause on each line.	Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause Final disease or condition resulting in death)	(R) lines	(ce	- mexus	tartie		Onset and Death
	/Medical Examiner		1	Due to (or as a conseque	nce of):				
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90	e exe cian ar urial-t		resulting in death) Last	Due to (or as a conseque	ence of):				
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_	certific Iding p		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance	cy			22d Date of delive	initia de la companya della companya della companya de la companya de la companya della companya
Box	that the death cer ed by the attendin detached for use	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3 Ectopic		in the second	23d. Date of delive Month	Day Year
P.0.	at the by the tache	hys	9 Unknown	9□ Unknown					
	res tha igned be det	ρχ	Part II. Other significant conditions con	tributing to death but not result	ing in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to th	14
ord	w require been si should I	Completed					1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
3ec	The law cate has b	mpje					24a. Was an autopsy	prior to cor	psy findings available apletion of cause of
Vital Records,	70		25 Was seen intered to make I				performed 1 Yes 2	death?	2□ No
	/sicia s certi directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1   Inpatient 2   EF	P/Outpatient 3 D	04	ath (Check only one)	a 🗆 🗆	
0	ng Phys ter this neral di		27. Manner of Death		8b. Time of Injury	28c. Injury at Work?	10me 5 Residence 28d. Describe how in		0
Sior	ttandin death. stor: Af	atlo	1 Accident 5 Pending investigation	(World, Day Your)	М	1 ☐ Yes 2 ☐ No			
Division of	l or Attending later death. Director: Alter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, facto	ry, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	Route Number,
			29a. Certifier Certifying Phys	sician: To the best of my knowle	edge, death occurred	d at the time, date and place	, and due to the cause	(s) and manner as st	ated.
	the h	Medical	A	ner: On the basis of examination and manner stated.					
)	To To	-	29b. Signature and title of certifier	(1)		C. License number	29d. [	Pate signed (Month, I	Day, Year)
			30. Name and address of person who co	mpleted cause of death (tra= 3	3a) /Tuna (B-i1)	0) 0030	/	122/02	
		İ	So. Hallo allo address of person who co	10055 m	) 14551	1) 2050 Carrollst 5	alishand	mo 24	04
	Stat		31. Date filed (Month, Day, Year)	32. Progistrar's Signatur	10		y de la constante de la consta	1.11	
	Registra	ar	JAN 2 2 20	Ul paraces to	! Bosall	,			

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Ginger Reece. 9:30 PM 30 2007 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 3/3/1942 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Maryland 213-38-9588 64 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cecil 1 □Yes 217 No Rising Sun Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Little New York Road 21911 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self employed Health Care Provider 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur E. Roberts Ivoy Virginia Hudson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth J. Reece (Husband) 309 Little New York Rd., Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R. A. Ferris & Co. 2/1/07 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Tarring- Cargo Funeral Home, Aberdeen, Maryland 21001-33 21. Signature of Funeral Service Licensee 21001-3399 23a. Part1. Enter the disease, or comblications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of) Vasculitis disease or condition resulting in death) heymonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1⊡ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 21 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-transi certificate be execu and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a detached f page 2 s funeral director, neral Director: After filled in by the funera death. or A To the Hospital within 24 hours at To the Funeral C

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at

Physician

/Medical Examiner

3altimore, Maryland 21215-0036

4 Homicide

29a. Certifier

(Check only one)

Medical

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature an

P18600

and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St, Baltimore, Mp

LIU 31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wayne Edward Rison 2:01 AM 2007 January /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Birthplace (State or Foreign Country) If Under **Funeral** Year) Months Days 1**∑**M 2□F Director 239-56-8356 Maryland 26,1939 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director Indian Head Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20640 30 Delta Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ✓ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Wright ဥ George E. Rison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9320 Tayleos Neck Rd., Nanjemoy, Md. 20662 Executor Trina Coburn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23, 2007 Park Hill Cemetery Jan. Marbury, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. M00668 20640 23a. Part1. Enter lie di sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art fail are. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (F) al disease or condi-resulting in death) Physician /Medical Due to (or as a conse u nce of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 No ned by the Division or Vital Records, P.O. 9□Unknown 9 ☐ Unknown Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STEA 20 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner. Stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

31. Date file (Month, Day, Year) **JAN 2 3** 2007 Registrar

Office

				State of I	Maryland /				lealth a Death	and M		giene () ( Reg. No.	)7	03446
	Physici		1. Decedent's Name (First, Middle		Jean Russel	11					2. Date of Dee Month Janua	ry 28, 2007	7 <sup>Year</sup>	3. Time of Death 4:30 A.M.
	/Medio Examir		4a. Facility Name (If not institution,	give street and number						wn, or Lo	ocation of Death	4c. County	of Death Alle	
	Funeral Director		218-38-2400	6. Sex 7. 1 □ M 2 X F	Age (In yrs. last 66	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day November	706, 1940	9. Birth	place (State or Foreign BSV Virginia
	aryland show	-	Usual Residence of Decedent  10a. State 10b. County  Maryland A	llegany	10c. City, To	own or Lo	ocation	-	Barto	n				10d. Inside City Limits 1 ☐ Yes 2 No
	with the M a or 28a-f be notified	Directo	10e. Street and Number	Michael Road			10f. Zip	Code	21521			10g. Citizen of V	Vhat Cou	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any Injury or other treumatic event, the Medical Evar-iner must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decede Armed Force	X No	i	Was Deced If Yes, sped				ecify Yes or No- Rican, etc.)	14. Race Blace Specify	k, White,	can Indian, etc. White
Maryland 21215-0020	vithin 72 hounder. Ne. han "natura e Medical E	mpleted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College (1-4		6a. Dece (Give life.	dent's Usua kind of wo DO NOT us	rk done se retire	oation during most d) omemak		ing	16b. Kind of Bu	siness/In	ndustry
and 2	d be filed v ntal Hygie ed other t	B	12 17. Father's Name (First, Middle, I	0 .ast) Glenn Ralph Gi	ıthrie			nc			e (First, Middle, Grac	Maiden Sumam e Pearl Sis	e)	iic .
Mary	and 2 should saith end Me n 27 is mark ier treumati	ဥ	19a. Informant's Name/Relationsh Donald Lee Russe	nip (Type, Print)	. 1	19b. Maili	-				al Route Numberd, Barton,			o Code)
Baltimore,	Pages 1 ar nent of Hea int: If item 2 iry or other		20a. Method of Disposition  1 🗷 Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		are		osition (Name of the state of t			Ja	Date anuary 31, 2007	20c. Location -	-	own, State s, Maryland
Balti	permit. F Departm Importar any Injur		21. Signature of Funeral Service L			22	2. Name ar				Kenzie Fu reet, Lona			9
	Physician /Medical Examiner		23a. Part. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)											Approximate Interval Between Onset and Death
	ate be executed hysician end the burial-transit	ical Examiner		b	Due to (or as Due to (or as			01	of	m	al tra	rplant		Tycars
x 68760,	entificate be e ding physician se as the buria	장	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as	a conseq	quence of):							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be detached for use as the burial-transit	Physician/M	Part II. Other significent condition  Dia beks n									obacco use coi ∕es 2 <b>y</b> No		o the cause of death?
Records,	w requires t s been signe 2 should be	Completed by	dementia,	,								en autop <i>s</i> y med?	av	ere autopsy findings vallable prior to ompletion of cause death?
	ien: The law rtificate has stor, page 2.	Be Com	Carrent 25. Was case referred to medical examiner?	deep	ris 14	from b	0 / 41	le 61.		of Deat	1 □ Y	res 2 No	11	□ Yes 2□ No
ion of Vital	Attending Physicien: The kardeath. ector: After this certificate haby the funeral director, page	ဦ	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of I (Month,	atient 2 ER/ njury 28 Day Year)	Outpatier b. Time o		28c. Injui Wo			ome 5 🗆 <b>R</b> esid 28d. De <i>s</i> cribe h	lence 6 DOth		fy)
Division	tal or Atters after de el Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of	Injury - At home , etc. (Specify)	e, farm, st	reet, factor	y, office			28f. Location (S City or Tow		er or Run	al Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical		Physicien: To the be exeminer: On the basis and manner	s of examination		vestigation	, in my c			red at the time,		and due t	o the cause(s)
	o V wit		30. Name end address of person v	Mo completed source	Can l	A O (Tuna		00	021	18	8	Janus	47	29 2007
	Sta	À	Thomas J. 31. Date filed (Month, Day, Year)	Devlin 32. Rég			Doug	145	Ave	L	214 (41)	ng Ma	1 2	1539
-	Regist		JAN 3 (	0 2007	Maria L	X A	med							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1:10 A M 22 2007 JAN. RHODES EDITH MARY /Medical 4h City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CAROLINE DENTON CAROLINE NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 😿 F Yrs. 97 AUG.11, 1909 MARYLAND Director 220-52-9185 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show traumatic event, the Medical Exerciner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director **QUEEN ANNE OUEEN ANNE** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with USA 21657 29525 QUEEN ANNE HIGHWAY Items 23a 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced natural 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Coflege (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be sand Mental ! ZADA ALMA HUNTER LACY ARVEL ROBINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. BOX 275, WYE MILLS, MD 21679 HOLTON E. RHODES, JR/SON Item 27 other tra Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1 Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 Removal from State ST. PETER'S CEMETERY QUEENSTOWN, MD 1-25-2007 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur - uneral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. willer 408 S. LIBERTY ST., CENTREVILLE, MD 21617 Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** preumonez disease or condition resulting in death) day /Medical Due to (or as a consequence of) **Examiner** 48215 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Completed by Physiclan/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 BNo Ö ed by the 9 Unknown 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 2 No has page 2 certificate 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 Sign 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death After Division Hospitel or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie D004 22/07 Zw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 MARKET ST., DENTON, MD 21629 WAFIK I. ZAKI, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		•	1- State of Maryland / Department of He Certificate of Department of He			giene 007	03448
ı			1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Judith Anne Rock		Januar	,	///// M
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death		4c. County of Dec	eth
			Peninsula Regional medical Center Salis	shury		Wicon	nico
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		230-60-4333 1 M 2 X F 60 Yrs. Months Days		08-13-	1946	Virginia
	D >	1 }	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	anyla ehov	_	Tod. State Tob. County Tod. City, Town of Education				1 X Yes 2 □ No
	ith the Marylan or 28a-f ehow e notified at	Director	MD Somerset Princess Anne				
	death with the Maryland ma 23a or 28a-f ehow r must be notified at	Dir	10e. Street and Number 10f. Zip Code			10g. Citizen of What C	
	ath v		26471 Mason Webster Road 21853			US	
	ar de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh	
20	s aft	by F	1 □ Never Married 2 Married 1 □ Yes 2 No 3 □ Widowed 4 □ Divorced Year or Dates:	Specify:		Specify:	· * .
2-003d	hour fural		15. Decedent's Education 16a. Decedent's Usual Occupation	ion		16b. Kind of Busines	White
<u> </u>	n 72	Completed	(Specify only highest grade completed) (Give kind of work done dur	ring most of worki	ing	TOD, TAITO OF DOUBLOSS	a modestry
7	with ene.	E C	Elementery/Secondary (0-12) College (1-4or 5+) 12 none Bookkeeper			Dlumbing	Contractors
7 5	Hygi Hygi ther ent, I	Ö		8. Mother's Name	e (First, Middle,	Maiden Sumame)	GUILLACLUIS
and	d be	<u> </u>	Charles Poff	Inanit	a Scott		
5	mark mark	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and		-	r. City or Town. State.	Zip Code)
<u> </u>	d 2 sith ar	1 1	Gary Rock/Husband 26471 Mason Web				
a)	1 an Heal Heal	-	20a Method of Disposition 20b. Place of Disposition (Name of	! 0	Date	20c. Location - City o	
Бащтог	ages nt of nt of r or o		1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	1	( 10007		100
	it. Pi		'4 □Donation 5 □Other (Specify) Asbury U.M. Cemete		6/200/	Mount Ver	non, MD
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heaths and Mental Hygiens. Important; if item 23a or 28a-f ehow eny injury or other traumatic event, I'm Medical Examinat must be notified at once.		Hinman Fund	eral Hom			
			M00295 11673 Somes 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	rset Ave	., Prince	cess Anne,	MD 21853 Approximate
			shock, or heart failure. List only one cause on each line.			<b>6</b> 51,	Interval Between Onset and Death
I	hysician	0	/Immediate Cause (Final disease or condition resulting in death)  a. Intracrand hemoth	age			12 hours
	/Medical Examiner		/Immediate Cause (Final disease or condition resulting in death)  a.   Jhtacranal hemoth Due to (or as a consequence of):  Sequentially list conditions.  b.   Ltybuto (Ive Item Sive Item	,			
	- W		Sequentially list conditions, b	cant DI	sease		
	sit ed	iner	Sequentially list conditions, if any, leading to annihilate cause. Enter Underlying Cause (Disease or injury that intributed experts)				
	be executed ician and burial-transil	Examin	that initiated events resulting in death) Last  Due to (or as a consequence of):				
Š	cian cian ouria						
04/8	cate physi the I	dicai	d			·	
o ×	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
X Q Q	atten atten for us	hysician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of de Month	Day Year
	the a	ysic	1 Pes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown				
J.	that the de ed by the detached	ο.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I	23e. Did to	bacco use contribute	to the cause of death?
Š	ires tha signed I I be det	by	Taken, solver organization continuously to accomplying source growth		1 🗆 Y	. /	robably 4 Unknown
0	w requir been si should I	ted			- 0.01	63 20140 001	Toolabiy 4 Gorinionii
a C		ple			24a. Was a autop	sy prior to	utopsy findings available completion of cause of
r	The ate ha	Completed			perfor 1 ☐ Yes	med? death? 2☑No 1☐Ye	s 2□No
Vital Records,	Physician: The law this certificate has b ral director, page 2 s	Be	eyaminer?	26. Place of Death	Check only or	18)	
<u> </u>	hysic nis ce i dire	ဥ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:	4 🗆 Nursing Ho	me 5 🗆 Resid	ence 6 Other (Sp.	ecity)
0	ding Phys		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury a Work?	at	28d. Describe h	ow injury occurred	
<u></u>	tending leath. tor: After the funer	atic	2 Accident investigation M 1 Ye	s 2 No			
UNISION	r Atto	tiflo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (S City or Tow	treet and Number or F n. State)	Rural Route Number,
5	To the Hospital or Attending Powitin 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral	Certification;				, 5.2.5,	
	hour hour iner	al	29a. Certifier  (Check only 2   Medical Exeminer: On the basis of examination and/or investigation in my onin	, date and place,	and due to the c	ause(s) and manner a	s stated.
	n 24 n 24 he Fr	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opin and manner stated.	nion, death occurr	ed at the time, o	ate and place, and du	e to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier 29c. License n		2	29d. Date signed (Mor	th, Day, Year)
)			2 rule NAM DR. USHA MATESAN DOST	359		January	13rd 2007
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			7	
			1415 S. DIVISION ST, SALISBURY	1702	1804		
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist		31. Date filed (Month, Day, Year)  JAN 2 5 2007  32. Registrar's Signature  ORIGINÁL				
DH	/H 17 Rev 1/2	001	10 pour				
			ORIĜINAL				

			1 - For State Registrar	State of Mai	,	partment of F prtificate of		Mental Hy	giene Reg. No.	07	03449
	Physici /Medic		Decedent's Name (First, Middle, Last)		PATRICK	RICHARDSC		2. Date of De Month Januar	y 21, 2	oď7°	3. Time of Death 4:45 P M
	Examin	er	4a. Facility Name (If not institution, give s Glade Valley Nursi	ing & Reha		Walkers			Fre	y of Death deric	ek
	Funeral Director		5. Social Security Number 6. Sex 089-09-5123	7. Age	(In yrs. last birthda 90 Yrs.	y) If Under 1 Year Months Days	Hours Min.		, 1916	9. Birth Cou New	nplace (State or Foreign untry) York
ylarid z i z i 3-0036	should be filed within 72 hours after deeth with the Maryland nd Mental Hyglene. It marked other than "natural; or items 23a or 28a-1 show unatic event; it a Medical Exacting must be notified at	To Be Completed by Funeral Director	10a. State 10b. County Maryland, Frederick 10e. Street and Number 56 West Frederick 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Patrick Richardsor	Street  2. Was Decedent Evarued Forces? 1 ZYes 2 Not If Yes, Give Year or Dates: cation College (1-4or 5+)	WWII    16a. Dec (Gn   life)   Ho1	10f. Zip Code 2179 3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No seedent's Usual Occup ye kind of work done DO NOT use retired	lispanic Origin? (S an, Mexican, Puert Specity: lation during most of wor ment 18. Mother's Nar Anna H	ne (First, Middle odgens	14. Ra Bla Speci  16b. Kind of E  HOTE	S.A.  Ce - Americk, White  Graphy: W  Business/Fi  E1  me)	nican Indian, o, etc. Thite Industry
Dalilliore, Ma	permit. Pages 1 and 2 should be a should b		19a. Informant's Name/Relationship (Type Patrick J. Richard 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)  21. Signal re of Numeral Service 12a. Part 1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	amoval from State  all son / Son  amoval from State  all son state caused it e caused inee  Core  Due to (or as a	20b. Place of Discomplete, compared of the Ly Cro	ematory or other place oss Burial 22 Name and Addre COBERT E. 1201 NORTH	n Court, Park 1/ ss of Facility & MARKET lg, such as cardiac	New Man Date 26/07 SON FUN ST., FRI	rket, M Éastaig Cranbui VERAL HO EDERICK	o 217 rūKsd ry, N OMES,	TALE TALE TO THE PARTY OF THE P
, F.O. BOX 66/60,	w requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the burial-transit	by Physician/Medical Examiner	I cry, teading to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a  Both If yes, outcome of 1 Live birth 2 4 Pregnant at tile 9 Unknown	consequence of):  f pregnancy  Fetal death  so death	B □Ectopic pregnancy □ Other (specify) _ underlying cause giv		23 <b>a</b> . Did t	М	ate of delik onth	very Day Year the cause of death?
Jivision of Vital Records,	ding Physician: The la h. After this certificate hes funeral director, page 2	ertification; To Be Completed by	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	ospital: 1   Inpatient	BPW  2 DER/Outpatie  28b. Time Injury	ent 3 DOA Cth	26. Place of Dea	24a. Was auto perfe 1 Ves Ath (Check only of the Secribe 28d. Describe	one dence 6 Othor occu	Were aut prior to or death? 1  Yes her (Spec	topsy findings available ompletion of cause of 2 No
No.	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical Certif	4 Homicide determined  29a. Certifier 1 Certifying Physical Examination 2 Medical Examination (Check only one)	building, etc. ician: To the best of eart of manner state	my knowledge de examination and/or end.	ath occurred at the tin investigation, in my o	pinion, death occu	City or To	wn, State) cause(s) and r date and place	anner as , and due	stated
M	Sta Registr		A - DUNECSON / 31. Date filed (Month, Day, Year)	32. Registrar 2007	's Signature	Aprile	wow de	FRE	WEXIC	a,	40 21702

		4	1 - For State Registrar	State of	Marylar		artment o			Mental Hyg	iene	0.7	03450
			1. Decedent's Name (First, Middle, L	ast)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic	_	John Jerome Sch	ools						01		0 07	7:39 A M
	Examin		4a. Facility Name (If not institution, g.	ive street and num	ber)			m, or Location				ity of Death	
			5804 Sargent Ro	ad		to a biat to 1	Hyat	tsville	r 24 Hrs.	1 . D / D'		ce Geo	
	Funeral Director		5. Social Security Number 6. 577–58–4843	Sex 7	63	last birthday) Yrs.		ays Hours		8. Date of Birth (Month, Day,	Year)		otace (State or Foreign
			Usual Residence of Decedent		0.5					Mar. 2,	1943	wasn	ington, DC
	ylanc how	. [	10a. State 10b. County			ty, Town or Lo						1	IOd. Inside City Limits
	Ba-f-	cto	MD Prince (	Georges	Ну	attsvi	lle						1 ☐ Yes 2√∑ No
	or 28	Director	10e. Street and Number				10f. Zip Cod			10	0g. Citizen o		ntry?
	ath w		5804 Sargent Rd.	· · · · · · · · · · · · · · · · · · ·			207		-1-1-0 (0	N N -		SA ace - Americ	and Indian
	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deced	ces?	1.5.	was Decedent If Yes, specify (	Or Hispanic O Cuban, Mexica	rigin? (Sp an, Puerto	pecify Yes or No- Rican, etc.)		ace - Amend lack, White,	
33	urs af	þ	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give	9		1 ☐ Yes 2 🛣	No Specify	<i>/</i> :		Spec	ify: B.	lack
Š	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow fra Madical Exertiner cual be mullind at	Completed	15. Decedent's			16a. Dece	dent's Usual Od kind of work do	cupation	est of user	kina	16b. Kind of	Business/In	dustry
21	e. an r	npie	(Specify only highest g Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use re	etired)	ISI OF WOR	(mg			
7	ed wi	S	12th			Stat	ion Man	9				/METRO	0
ב	be fill H d oth	Be	17. Father's Name (First, Middle, Las John William Sch	,						e (First, Middle, M		ame)	
<u>\S</u>	d Mer narke	ဥ			<del> </del>	10h Maili	- Add (Ct			Scribner		- Ct-t- 7:-	Cortol
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if health and Mental hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other treumatic event, in Mardical Exertiner challes and the rutilinal at		19a. Informant's Name/Relationship  Jeralonza A. Sch		ah te a se								
စ်	permit. Pages 1 an Depertment of Heal Important: if item 2 eny injury or other once.		20a. Method of Disposition	ioors/pau	20b. I	Place of Dispo	sition (Name o	if I	DI.	Hyattsv Date 2	20c. Location		
و ج	Pages nent of int: if it		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spec		tate		natory or other itan Cr		v 1 –	27-2007 A	lavan	dria	VΔ
	Depertment Popertment Importar eny knjur		21. Signature of Funeral Service Lic		TIC		2. Name and Ad			Marshall'			
ñ	Depermine Depermine Impo		Pman	linger.		4	1217 9t	h. St.		. Washing			
	7K -\$1		23a. Part. Enter the disease, or co sheck, or heart failure. List on	mplications that ca	used the deal	th. Do not en	er the mode of	dying, such a	s cardiac	or respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Heart	Failur	е					Onset and Death  6 years
146	/Medical		resulting in death)		or as a consec								
4	Examiner	L	Sequentially list conditions,	b	iomyop								
	led isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c	or as a consec	quence or):							
	n end	Examiner	that initiated events resulting in death) Last	cDue to (c	or as a consec	quence of):							
8760	The law requires that the death certificate be executed tie has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	dicai E		d									
89	tificat ig phy as th	edi											
ŏ	death certific attending pl	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregn		Ectopic pregna	ancy				ate of delive	*
m	s deal	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		int at time of o		Other (specif)				N	Month	Day Year
P.O. Box	w requires that the death cer been signed by the attendin should be detached for use	Physician/Med	9 Unknown					In Book		22 Didust		-1.15	
JS,	signe bed	Ď	Part II. Other significant conditions Hypercholes			suiting in the u	nderrying cause	e given in Part	1.		s 2 $\square$ No		ne cause of death?
Ö	requ been shoulk	Completed	Hypertensic		a					-			
ě	has l	d E	nypertensic	711						24a. Was ar autops perform	y	prior to con death?	psy findings available mpletion of cause of
ē		ဝင္ပ	25. Was case referred to medical							1 ☐ Yes 2	! □ No	1 ☐ Yes	2 No
5	Attending Physicien: The la r death. ector: After this certificate has by the funeral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nationt 2	] ER/Outpatier	1 3 DOA	Other		th (Check only one ome 51X Reside		than (Canai	
Ö	g Phy er this eral c		27. Manner of Death	28a. Date o		28b. Time o		Injury at Work?	idising it	28d. Describe ho			<i>y</i> /
Ö	Attendin death. ctor: Aft y the fun	atio	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigati	on	, Day 1 dai/	Injury		1 Yes 2	]No				
Division of Vital Records,	i or Attending Phater death. Director: After th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At h g, etc. (Speci	ome, farm, sti	eet, factory, off	lice		28f. Location (Str. City or Town	reet and Nun , State)	nber or Rura	al Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the												
	e Hospital 24 hours a E Funerel I etely filled	edical	29a. Certifier 1 ☑ Certifying I (Check only one) 2 ☐ Medical Ex-	Physicien: To the laminer: On the ba	sis of examina	owledge, deat ation and/or in	h occurred at th vestigation, in r	ne time, date a my opinion, de	ind place ath occu	, and due to the ca rred at the time, da	iuse(s) and rate and place	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and mann	or sidled.		29 <u>c</u> . Lic	cense number		29	9d. Date sign	ned (Month.	Dey, Year)
	F 3 F 8		18D Fu	ke Ver	air	4D	Do	0026	9-	7 2	1-2	22-	-07
)	(0)		30. Name and address of person wh	o completed cause	of death (Iter	m 23a) (Type.	-		- 1				
_	(2)		Ellen D. Fi					t Rd.	Hyat	ttsville,	Md.	20782	
ut.	Sta	ite	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1- State of Maryland / Dep	partment of Health and Nertificate of Death		ne 2007 03451
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
b	Physic /Medi		THERESA SIMMONS		Month (5.1	Day Year 190/M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director		578-50-6872 1□M 2□F 67 Yrs.	Months Days Hours Min.	Oct. 7. 1	939 Washington, D.C.
	and w	7	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation		
	Aaryli f sho ed at	5	Maryland Prince Georges Clinto			10d. Inside City Limits 1√∑Yes 2 ☐ No
	the 1 28a- notifi	Director	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	3a or					,
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Completed by Funeral	11402 Cosca Place	20735  Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		United States  14. Race - American Indian,
9	after or ite	₫	1 Never Married 2 Married 1 Yes 2 No		Rican, etc.)	Black, White, etc.
8	ours iral",	d b	3 ☐ Widowed 4₺ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 H No Specify:		Specify: Black
S.	72 h 'natu dical	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	16b	o. Kind of Business/Industry
121	within ane.	ם		ousekeeper		Private
d 2	Hygie Hygie ther	ပ္သ	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
an	ld be ental ked o	To Be				uen Surname)
J.	shoul nd M mari	F		Vivian ing Address (Street and Number or Rur		ity or Town State Zin Code
ž	nd 2 alth a 27 is		·			Washington, D.C.2001
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disp			. Location - City or Town, State
E	Page nent c int: If		1 ☐ Burial 2 ☎ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Metropo	1	4 2007 A	lexandria, Va.
ati	permit. Departr Importa any inju			2. Name and Address of Facility		
<u> </u>	8 3 2 6 6	0 11	Kut a. Herry MUIOSE	Alexander S. Pope 5538 Mariboro Pik	e/Forestv	ille, Md. 20747
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
1	Physician	1	Immediate Cause (Final disease or condition	RIC ISCHEM		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		C 1 - 1-1	
Е	Lammer	_	Sequentially list conditions, b. ENDOCAR	DITIS		
	ted nsit	Examiner	if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	execu and al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit	edical [	d			
9	tificat ig phy as th	ledi				
ŏ	death certific attending pl	N/UE	IF FEMALE:   23c. If yes, outcome pf pregnancy   23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1			23d. Date of delivery
m	death	sicia		Other (specify)		Month Day Year
Records, P.O. Box	w requires that the debeen signed by the should be detached	Physician/M	9 ☐ Unknown 9 ☐ Unknown			
Ś	res th igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the t		23e. Did tobacc	to use contribute to the cause of death?
oro	requii	ted	DIABETES, HYPERLIP	I DEMIA	1 ☐ Yes	2 No 3 Probably 4 Unknown
ec	law hasb	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	: The law cate has	Co			performed' 1 Yes 2 □	?   death?
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
ō	Phys this	2	1  Yes 2 No Hospital: 1 Inpatient 2 □ ER/Outpatie	- / Training floi		6 ☐Other (Specify)
o	ding h. After fune	ion	1 Natural 5 Pending (Month, Day Year) Injury	f 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Division or	after death after death Director:	lical	3 Suicide 6 Could not be 28e Place of injury. At home farm at		29f Longtion (Chross	and Musels and Allert Annual A
2	after after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	zet, ractory, emice	City or Town, Sta	and Number or Rural Route Number, ate)
	hours hours inera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	h occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in and panner stated.	vestigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To t To t com	Σ	29b. Signature and little of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
)			he ho MI	) A44176435A1	5944 1	117/07
R	_(5)		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		
			31. Date filed (Month, Day Year)  32. Registrar's Signature	ST BAITIMORE,	MD Z	1201
	Sta	(e	31. Date filed (Month, Day Year) 32. Registrar's Signature	,		

Registra

			For State	State of Ma	arylan		artmen			and Me		0	007	0.2	1 5
			Registrar  1. Decedent's Name (First, Middle, Last	1		Cei	lilicali	e or L	Jeani		2. Date of De	Reg. No.	UUI	3. Time of	Death
	Physicia	an			572	DUT					Month	Day Z\	Year	060	
	/Medic		RICHARD A 4a. Facility Name (If not institution, give		-7 , (	00, (	4h City	Town or	Location of	of Death	Jan		unty of Death		
	Examin	er	Shady Grove Adven		ital		Rock			., 200			tgomer		
	Funeral		5. Social Security Number 6. Se		e (In yrs. i	last birthday)	If Under	1 Year	If Under		8. Date of Bird	th	9. Birthi	place (State o	or Foreign
	Director		148-16-8157	<b>X</b> M 2□ F	79	Yrs.	Months	Days	Hours	Min.	Month, Da April 1	l 8 <b>,</b> 192	7 New	Jersey	
1	ъ		Usual Residence of Decedent		T									40.11. 11.0	
	rylan how	_	10a. State 10b. County  Maryland Montgome	W17		y, Town or Lo tomac	cation							10d. Inside C 1 ₩∨es	2 □ No
	e Ma Ba-f s	cto			100	Comac	1					40 000	(111)		
	or 2	Ö	10e. Street and Number				10f. Zip					U	of What Cou		
	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral Director	9736 Beman Woods		e 1- 11	0 40		854	!!a O-!	ning (Cno.	oifu Vaa ar Na		d Stat Race - Ameri		
	er de Items	nue	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 X Yes 2 ☐		.5. 13.	If Yes, spe	cify Cuba	an, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)	14.	Black, White,		
20	hours after tural", or ite al Examine	by F	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2∏xNo	Specify:			Sp	ecify: Wh	ite	
9500-c	hour tural	ed	15. Decedent's Edu	cation	War -	16a Doce	dent's Usua	al Occup	ation			16b. Kind	of Business/Ir		
2	n "ng n "ng Medig	plet	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or !	5+)	(Give life.	kind of wo DO NOT us	rk done d se retired	during mos d)	t ot workin	g				
7	filed within 72 Hygiene. Ither than "na'	Completed	Elementary/occordary (5 12)	4		Insu	rance	Exe					urance		
<u> </u>	be filed within 72 hours after death with the Marylan Hygiene. Hygiene. do ther than "natural", or Items 23a or 28a-f show to ther than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					İ			(First, Middle,		rname)		
yland	uld b Ments Irked Itic e	To	Rutherford Jones	Stout					Han	nah I	Bennett	<b>:</b>		_	
Mar	jes 1 and 2 should be filed w of Health and Mental Hygie If Item 27 is marked other ti ir other traumatic event, th		19a. Informant's Name/Relationship (T	/pe. Print)		19b. Maili	ng Address	(Street	and Numbe	er or Rurai	Route Numb	er, City or To	own, State, Zi	p Code)	
≥ .	and n 27 ner tr		Nancy Brasch Stou	t/ Wife	Tool 5				venue		thers				
o ce	of H		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ i	Removal from State	206. F	Place of Dispo ce <i>metery</i> , cre. Gate	matery or o	me or other place Baver	ce)		ry 26,	Silve	ion - City or T er Spri	$\log$	
Ē	ment tant: Jury		4 □ Donation 5 □ Other (Specify	1		Ceme	tery			200	7	Man	yland	0 5	
Baitimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		21. Signature of Funeral Service Licens	iele /		1					ol Fune ithersh		•		
_			1/20	My	1								FID 200	Approxima	to.
			23a. Part 1. Ether the disease, or comp shock of rear trailure. List only of Immediate Cause (Final disease of condition	ne cause on each li	ine.	n. Do not en	ter the mod	de or dyli	ig, sucri as	Cardiac O	respiratory a	iresi,		Interval Be Onset and	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)				ROK	E						DAY 5	•
	/Medical Examiner			Due to (or as	a conseq	uence of):									
		<u></u>	Sequentially list conditions,	b Due to (or as	a conseq	uence of):									
	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	`											
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):									
/60,	ate be executed hysician and the burial-transit	lical		d											
200	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	edic		ч											
X Q R	death certifical attending phy of for use as the	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			⊒Ectopic p	reananc	u			230	. Date of deliv	,	
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (s						Month	Day	Year
э Э	s that the de ned by the a detached f	Physician/Med	9 □ Unknown								Т				
	es tha igned be de	by F	Part II. Other significant conditions of	ontributing to death t	out not res	sulting in the u	ınderlying (	cause giv	en in Part I	l.			contribute to		
Records,	w require been sign										1 🗆	Yes 2	No 3∏Pro	idabiy 4 🗆	Unknown
ပ္ပ	law r as be	ple									24a. Was	psy	24b. Were aut prior to c	opsy findings ompletion of o	
	The ate h page	Completed									perfe 1 Yes	2 No	death? 1 □Yes	2 No	
Vita	Physician: The lav r this certificate has ral director, page 2	Be (	25. Was case referred to medical examiner?	11 9-1 - 4				0.11		e of Death	(Check only	оле)			
	Physic this o	၉	1 ☐ Yes 2 No	Hospital: 1 Inpati		ER/Outpatie			4 □ N		ne 5□Res			ify)	
ב	r Attending Pher death. Irector: After the by the funeral	.: ::	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da		28b. Time of Injury		28c. Injui Wor			28d. Describe	now injury o	ccurred		
Sio	Attending r death. ector: After by the funer	cati	Accident investigation  3 Suicide 6 Could not be	One Place of in	iun. At h	ome, farm, st	M factor		Yes 2		28f. Location (	'Street and A	lumbar or Du	m I Pouto Nu	mher
Division or	or Attendated death	Certification:	4 ☐ Homicide determined	28e. Place of in building, e			icoi, idoloi	y, onice				wn, State)	umber of ria	ar riodie rvar	nooi,
	To the Hospital or A within 24 hours after. To the Funeral Directory filled in by		29a. Certifier 1 CertifyIng Ph	ysician: To the best	t of my kno	owledge, dea	th occurred	d at the ti	me, date a	nd place, a	and due to the	cause(s) ar	nd manner as	stated.	
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Exam	niner: On the basis	of examina	ation and/or i	nvestigatio	n, in my	opinion, de	ath occurr	ed at the time	, date and p	ace, and due	to the cause	(s)
	o the	ĕ	29b. Signature and title of certifier				29	c. Licens	se number			29d. Date s	igned (Month	, Day, Year)	
1			1 Account Own	mod			ĺ	06	1444	(		Janu.	wy 2	1,200	7
<b>7</b> 1	1841		30. Name and address of person who												
			Arijit Dasgupta,						ive,	Rocky	zille,	MD 20	850		
		ate	31. Date filed (Month, Day, Year)  JAN 23 2	007 32. <b>S</b> gist	trar's Sign	ature	hart								
	Reaist	rar	UNIT NO L	JU:	West .	JJ. A									

			- State	ertificate of Death	, ,	g. No.	00.00
*. **. *******************************	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
P. Alley	/Medi		FRANCES MARIE STEVENS		JANUARY	Day Year 19 2007	4:50 A M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Death	1
N) S	er elle ordinario de la constanta	76.	460 Girard Street, #101	Gaithersburg		Montgom	ery
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 M F  7. Age (In yrs. last birthde	Months Dave Hours Min			nplace (State or Foreign Intry)
1.4	<u> </u>		Usual Residence of Decedent		Aug. 22	1948 M	aryland
	arylar show	_	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	e Ma Ba-f s	50	Md. Montgomery Gaither	rsburg			1 XYes 2 No
	ith th	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	intry?
	ath v s 23a nust l	<u>ra</u>	460 Girard Street, #101	20877		United Stat	tes
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	, etc.
5-0	72 h 'natu dical	etec	15. Decedent's Education (Specify only highest grade completed) (Gi	edent's Usual Occupation	16	6b. Kind of Business/Ir	ndustry
21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of w . DO NOT use retired) memaker	orking	Or to Home	
D 2	Hyg other ent, t	Be C	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	Own Home	
jan	lld be fenta rked ric ev	To B	Roscoe Auvil	Prisci		Bowman	
ary	shou and N s mai	-	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or F		City or Town, State, Zin	o Code)
Σ	and 2		Earl G. Stevens / Husband 460	Girard Street, #	101, Gaith	ersburg, N	1d. 20877
ore	of He		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Discemetery, compared to the comparison of the comparison of the compared to the c	oosition (Name of ematory or other place)	Date 20	c. Location - City or Te	own, State
Ē	Pag ment ant: I		4 □ Donation 5 □ Other (Specify) Parklaw		23/07	Rockville,	Md.
Baltimore, Maryland	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee  Mercef H. Barker	22. Name and Address of Facility Muriel H. Barbe P. O. Box 5038	r Funeral		
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		ac or respiratory arrest	i,	Approximate
	Physician		Immediate Cause (Final disease or condition RESPTRATORY	FATLURE			Interval Between Onset and Death
ä	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	-11201			
	Examiner	_	Sequentially list conditions, b. MUSCULAR DYS	TROPHY			
	ted isit	nine	training to immediate cause. Enter Underlying Cause (Disease or injury)				
	and al-trar	Examiner	Sequentially list conditions, if a y, leading to finine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):				
68760	ficate be executed physician and is the burial-transit						
89	ifficate g phy as the	Medical	d				
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
J.	that i		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobac	co use contribute to the	no ocupo of double?
Kecords,	w requires been sign should be	2		arth, mg edeco givon in r diti.		2 No 3 Prob	
ပ္ပ	law re as bed 2 sho	plet			24a. Was an	24b. Were auto	nsv findings available
		Completed			autopsy performed 1□ Yes 2	death?	psy findings available npletion of cause of 2□ No
VItal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		ath (Check only one)		
_	Je iši je	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	- I Training (	lome 5 ⊠ Residence	e 6 □Other (Specify	)
0	th. : After s funera	tion	27. Manner of Death  1 1 2 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how i	injury occurred	
DIVISION	To the Hospital or Attending Please within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)		28f. Location (Stree City or Town, S.	t and Number or Rural tate)	l Route Number,
:	n 24 hours n 24 hours ne Funera	ledical C	29a. Certifier (Chick chily one)  1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or i and manner etated.	th occurred at the time, date and place envestigation, in my opinion, death occur	e, and due to the cause urred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	vithi To ti		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
	/		Thenene Wrolden in	D0064615		JANUARY 1	9, 2007
	5		30. Name and address of person who completed cause of death (Item 23a) (Type				
			GENEVIEVE WROBLEWSKI, M.D. 1355	PICCARD DRIVE, ROO	CKVILLE, M	D. 20850	
	Stat Registra	e er	31. Date filed (Month, Day, Year)  JAN 2 3 2007  33 Registrar's Signature				

Box 68760 physician as the for use of Vital Records, P.O. funeral director. After t Division

Singer, Harol

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

or 28a-f ehow

23a

or items

the Medical Examiner must be notified at

Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit To the Hospins after death.
Within 24 hours after death.
To the Funstal Director: After

Certification: To 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

29b. Signature and title of pertifier Muck 29c. License number

D0061934

29d. Date signed (Month, Day, Year) January 21, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Road, Rockville, Maryland Dr. Andrew Kundrat

N 2 3 2007 31. Date filed (Month, State Registrar

		,	1 - For State Registrar		State o	f Mar	yland	-			lealth a			Reg. No.		7	0345	5
	Physici	an	Decedent's Name (First, Min		3	. 1							2. Date of De Month	Day		ear	3. Time of Dea	eth M
	/Media	al	4a. Facility Name (If not institu	line .			ens		4h City	Town or	Location of	of Death	January		2007 County of		0835	141
	Examir	er	Union Hosp				ັດນກ	tv	4b. Oity,		Elkto			40.	County or	Ceci	1	
	Funeral		5. Social Security Number	6. Sex				ast birthday)	If Under Months		If Under Hours		8. Date of Bir (Month, Da	th V Vear	9		ce (State or Fo	reign
	Director		215-40-0833	1 🗆 1	vi 21€ F	6	6	Yrs.	MOTILITS	Days	Hours	IVAIL1.	Oct. 2	2, 19	40		yland	
pug	*		Usual Residence of Decedent 10a, State 10b, Cou	nty	-	1	I0c. City	. Town or Lo	cation							100	I. Inside City Li	mits
Maryl	de la para	ro	Maryland	Cecil					No	rth	East						1 ☐ Yes 2 🛭	3 No
the the	128e	Irec	10e. Street and Number						10f. Zip	Code				10g. Citi	zen of Wha	t Country	/?	
th wit	23a o	ai D	33 Dr. Carr R	oad						2	21901				U.	S.A.		
1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23s or 28s-1 show any ridury or other traumatic event, the Medical Examinat must be notified at ance.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ N	arried	2. Was Dec Armed Fo 1 ☐ Yes If Yes, Gir	orces? 2⊠No	er in U.S				ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	)-	14. Race - Black, ' Specify:	White, etc	C.	
<b>21215-0036</b> od within 72 hours af	ural.	d b	3 ☐ Widowed 4 ☐ Divord		Year or D	ates:								40h K:			ite	
15- 1721	inet Falles	Completed	(Specify only hig		completed)			16a. Dece (Give life.		rk done d	during mos	t of work	ing		nd of Busin • Med		Center	:
7 <u>F</u>	then the M	omp	Elementary/Secondary (0-1:	·	College (				File	cle	erk			Per	ry Po	int,	Maryla	ind
ם 🖁	othe vent,	BeC	17. Father's Name (First, Midd	le, Last)							18. Mothe	er's Name	First, Middle	, Maiden	Sumame)			
Maryland	Menta arked atice	10 E	Pau	L M. S	Stephe	ens							atherin					
Aar 2 sho	ie m		19a. Informant's Name/Relation		•	\			•				al Route Numb	_				
6, 6	Health em 27 ther t		Glenna S. Fle  20a. Method of Disposition	ning	(Sist	.er)	20b. PI	ace of Dispo	CONTRACTOR DESIGNATION AND ADDRESS OF	CONTRACTOR	Erde		, Penns Date		nia cation - Cit		736 n. State	
nor	nt of t		1 Burial 2 ☐ Crematio		moval from	State	C6	pewell	natory or c	ther plac	- 1						Maryla	and.
Baltimore, permit. Pages 1 a	Departme Important any injury ance.		4 □Donation 5 □Other  21. Signature of Funeral Serv	-	1000		<	22 Le	2. Name ar	d Addres	ss of Facili terso	ty n &	Son Fun	neral	Home		-	ind
			23a. Part1. Enter the disease shock, or heart failure.	or complication one	ations that of	caused the	ne death		-			_	d 2190 or respiratory a		66	l Ir	approximate nterval Betweer Onset and Deat	
,	ysician		Immediate Cause (Final disease or condition resulting in death)	_ a.		ادس											AYS	
	Medical kaminer		resulting in death)	1		1.0		ience of):									Marie	
		e e	Sequentially list conditions, cause. Enter Underlying	b.		PS I		ence of:								-	PATE	
petn	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>【</b> .	Ac	u TE	R	ENAL	FALL	ur	£					1	DAYS	
60, be executed	hysicien and the burial-transit	Exa	resulting in death) Last		Due to	(or as a	consequ	ience of):										
9	nysici he bu	ical		d.												-		
C 68	ing ph e as th	Med	IF FEMALE:											- 1				
. Box 68 death certifica	ettending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23	c. If yes, ou 1 ☐ Live t 4 ☐ Pregr	birth 2	Fetal	death 3[	∃Ectopic p					1	23d. Date o Month	,	ay Year	
O. F	by the crached	iysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		9□ Unkn		ille or de	54U1 3L	_ Other (st	ocny)								
o ₹	pe de	þ	Part II. Other significant con-	litions conti	nbuting to d	leath but	not resu	ulting in the u	nderlying o	ause give	en in Part I	l.					cause of death	
Vital Records, sician: The law requires t	hes been s je 2 should	Completed											24a. Was	an	24b. We	re autops	y findings avai	lable
	pag	Com											perfo 1 ☐ Yes	ormed?	+ dea	th?	₽No	
/ita	certificete rector, pag	Be	25. Was case referred to med examiner?		anital.					104		of Deat	n (Check only o	one)				
of Vita Physician:	di B	5	1 ☐ Yes 2 ☐ No 27. Manney of Death	HO	spital: 1 28a. Date	Inpatient	2 🗆 1	ER/Outpatier 28b. Time o			7 🗆 140		me 5 Resi			(Specify)		
	After fune	tion	1 ■Natural 5 □ Per	iding estigation	(Mor	th, Day	Year)	Injury	M	28c. Injun Worl 1 □	k? Yes 2□		zou. Describe	now injur	y occurred			
Division For Attending	tor: the	Certification:	3 ☐ Suicide 6 ☐ Co	ild not be ermined	28e. Place	e of Injury	y - At ho	me, farm, st	reet, factor	y, office			28f. Location ( City or To			or Rural F	Route Number,	
D is	s afte	Cert	4 [] Hamilde		Dulid	ling, etc.	(Зреспу	·)					City of 10	wn, State	,			
Di Mospital or	within 24 hours after of To the Funeral Directompletely filled in by	edical			er: On the b		xaminat						red at the time,					
੍ਰ ਜ	To the	Me	29b. Signature and title of cer	ifier						_	e number			29d. Dat	e signed (/	Month, Da	ly, Year)	
)			1 4	<b>10</b>						DOOI	1771	(		JAN	アンチン	99	,2007	
	4		30. Name and address of personal DANIO 6M-6		4-30	6 N	Jart)	L Stre	cet S	iulte	*3	ELH	אין מנד	لایم و	Amb	2193	21	
	Sta Regist		31. Date filed (Month, Day, You JAN 2 3		El a	Registrar'	's Signal	ture for	de la									

			1 _ State	State of M	larylan		artmen rtificat					(1)	007	n'	31.56
			1. Decedent's Name (First, Middle, La	ist)		Cei	incai	e or L	aiii		2. Date of De	Reg. No.	007	3. Tit	me of Death
	Physicia	an		teward							Month January	Day	2007		004AM
	/Medic		4a. Facility Name (If not institution, give		)		4b. City,	Town, or	Location		Junuary		ounty of Dea	ith	- 17
	Examin	er	Union Hospital	,			E1	kton					Cecil		
_	Funeral		5. Social Security Number 6. S		ge (In yrs.	last birthday)	If Under		If Under		8. Date of Birt	h Vear	9. Bi		tate or Foreign
	Director		196-28-0732	<b>7€</b> M 2□ F	69	Yrs.	Months	Days	Hours	Min.	(Month, Da Aug. 25	, 1937	Wi	ountry)  Iming	ton, DE
	P _		Usual Residence of Decedent		110 0									104 100	ide City Limits
	arylar ahow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation								Yes 2 No
	Ba-f	5	DE New Cas	tle	Be	ear						10 011			
	ith th	Director	10e. Street and Number 511 Hunter's R	un Harr			10f. Zig	701					in of What C	ountry !	
	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other then "natural", or items 23a or 28a-f ehow event, the Medical Examiner must be mullied at	ral		12. Was Decedent	Ever in II	C 12	1		ispanic Or	igin2 (Sne	cify Yes or No		. Race - Am	erican Indi	an
	item item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces	?	.3.	If Yes, spe	cify Cuba	n, Mexica	n, Puerto	Rican, etc.)		Black, Whi	ite, etc.	
Maryland 21215-0036	urs af	by	3    Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 🔼 No	Specify	:		S	pecify:	white	
Ş	2 ho	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usu kind of wo	al Occupa	ation	et of worki	na	16b. Kind	of Business	s/Indiustry	
בן בו	hin 7	ple.	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired	1)	or works	· · 9				
7	or th	Son	12			Flig	ght E	ngin					. Air	force	
פ	d oth	Be	17. Father's Name (First, Middle, Las	<sup>()</sup>							(First, Middle,				
<u>X</u>	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. ie marked other then "natural", or items 23a or 28a-1 ehow airmatic event, the Madical Examiner creat he notified at	ဥ	Arthur Steward								s Blans				
<u>a</u>	2 sh and ie m		19a. Informant's Name/Relationship Cheryl Steward (				-				<i>l R</i> oute Numbe ncinita				
ຜົ	t end feelth m 27		20a. Method of Disposition	laughter)	20b. F	Place of Dispo			IIC L		ate		ation - City o		ate
0	to the state of th		1 ☐ Burial 2 ☐ Cremation 3			Lverbro	matoniori	thar nian	<b>(e)</b>						
Baltimore,	t. Pa rtmer rtant nlury		4 □Donation 5 □ Other Speci 21. Signature of Fuheral Service Light		0018	Lverbro	Name a	rema	cory	itv			lilmin		
Ba	permit. Pages 1 end 2 should be Department of Heelih and Menia Important: If item 27 ie marked any injury or other traumatic e <u>once</u> .		Mukilo 4 H	Leoly .	0070		icCre Vilmi				mes, In	c. 39	24 Co	ncord	Pike
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause	ed the deat line.	h. Do not en	ter the mod	de of dyin	g, such as	s cardiac o	or respiratory a	rrest,		Interv	ximate al Between
	Physician		Immediate Cause (Final disease or condition	Senti	1: C	linch	. Z	0 0	erla	rel	El Vi	SCAIS		Onset	and Death
	/Medical		resulting in death)	Due to (or a	s a conseq	luence of):		-	y		nd co				
П	Examiner		Sequentially list conditions,	b. c	Scre	n h	m	2 has	SLO	. C	no co	rdie	<u>e</u>	5	dens
	P #	Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	(uence of):	, ,								
	end end -tran	каш	that initiated events resulting in death) Last	c. Due to (or a	S a cooseo	juence of):	_					-			A-A-80 - M
8760,	icate be executed physicien end s the burial-transit	E I		220.10 (0.12	,										
87	phys the	dical		d											
9 X	ding se as	by Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregna	ancy						23	d. Date of de	eliverv	
Вох	atten for u	ciar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant a			□Ectopic p □ Other (s		/				Month	Day	Year
o.	the d y the	lys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
٠. ت	s that ned b	Ϋ́	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	ınderlying	cause giv	en in Part	l.	23e. Did t	obacco use	e contribute	to the caus	se of death?
Sp	quires in sign	q pe	chrome p	concrecti	(lis	, h	0.11	Tru	cn	d	10	Yes 2√2	No 3□F	Probably	4 Unknown
00	s bee	Completed	humelisid	emil.							24a. Was		24b. Were a	autopsy fin	dings available in of cause of
Re	The It	E									autor perfo	med?	death?		
<u>a</u>	an: tifice tor, p	Be C	25. Was case referred to medical						26. Plac	e of Deat	n (Check only o				
>	ysicl is ce direc	To	examiner? 1 ☐ Yes 2√ No	Hospital: 1 Impat	tient 2	ER/Outpatie	nt 3 D	OA Oth	ier: 4 🗆 N	lursing Ho	me 5 Resi	dence 6	□Other (Sp	ecify)	
0	ng Ph ter th neral		27. Manner of Death (	28a. Date of In (Month, D	jury Jay Year)	28b. Time o	of	28c. Injur Wor	y at rk?		28d. Describe	how injury	occurred		
Sio	Attending Physicien: The law requires that the death certific releath. ector: After this certificete has been signed by the attending p by the funeral director, page 2 should be deteched for use as	Satio	2 Accident investigation	-			М		Yes 2	]No					
Division of Vital Records, P.O.	after danger de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	288. Place of II	njury - At h etc. <i>(Speci</i>	iome, farm, st fy)	reet, factor	y, office			28f. Location ( City or To		Number or F	Rural Route	e Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be deteched for use as			Physician: To the bes											ause(s)
	To the H within 24 To the F complete	Aedical	one)	and manner s											
١	To Toon	Σ	29b. Signature and title of certifier	â			25		se number			ZSU. Date	signed (Mor	iii, Day, T	
,			1 Cum	là Tuhi	~	1)					50	20	n) 22	- /2	J 60 C
į.	2		30. Name and address of person who		death (Iter	m 23a) (Type,		21	=	- In IL	TON	MI	> `		
	<i>○</i>	ate	31. Date filed (Month, Day, Year)			ature 1		200							
	5.		IAN 2	4 2007	8-2.40	. 18	11100	125							

Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23a or 28s-1 show eny injury or other traumatic event, its Medical Examinar mini be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and compiseley filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

State Registrar

	Registrar	C	enincale of Dealin	Reg.	No.	
ın	Decedent's Name (First, Middle, Last)	_			Day Year	3. Time of Death
al	WILLIE E.	THOMAS		1	9-07	5:47 A M
r	4a. Facility Name (If not institution, give street and nun WASHINGTON ADVENTIST		4b. City, Town, or Location of Death TAKOMA PARK	٦	4c. County of Death MONTGOM	
		7. Age (In yrs. last birthda	v) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birth	nplace (State or Foreign
	244-58-1210 1XM 2□F	66 Yrs.	Months Days Hours Min.	(Month, Day, Ye 2-22-40	NORT	H CAROLIN
	Usual Residence of Decedent	10c. City, Town or	Landina			40d Inside City Limite
_	10a. State 10b. County					10d. Inside City Limits  ↑▼□ Yes 2 □ No
ב נ	MD MONTGOMERY  10e. Street and Number	TAKOMA	PARK 10f. Žip Code	100	Citizen of What Co	21
ŝ			20912		U. S. A.	•
2	1006 FAIRVIEW AVENUE	dent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Amer	ican Indian,
Ē	Armed Fo 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes	2€ No	If Yes, specify Cuban, Mexican, Puert	o Hican, etc.)	Black, White	
2 0	3 Widowed 4 Divorced If Yes, Giv Year or Da	e ates:	1 ☐ Yes XIXNo Specity:		Specify: D1	IACK
	15. Decedent's Education (Specify only highest grade completed)	(Gir	cedent's Usual Occupation we kind of work done during most of work	d . i =	DETNIC M7	ndustry ANAGEMENT
Completed by Funeral Director	Elementary/Secondary (0-12) College (1	-4or 5+)	. DO NOT use retired) ERVISOR	FA	KKING MA	INC.
3	17. Father's Name (First, Middle, Last)			me (First, Middle, Mai	den Sumame)	INC.
0	EDWARD THOMAS		MARY	DALTON		
•	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Street and Number or Ru		ity or Town, State, Z	ip Code)
	MARGARET THOMAS-V	VIFE 1000	6 FAIRVIEW AVE.	TAKOMA	PARK, N	ID 20912
	20a. Method of Disposition	comptant of	position (Name of rematory or other place)	Date 200	. Location - City or 1	Fown, State
	XXBurial 2 ☐ Cremation 3 ☐ Removal from 3 ☐ Donation 5 ☐ Other (Specify)	State		7-07 E	DEN, NC	
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility $PI$			F. H.
	Theodore Co in	ickney!	524 - 8TH ST.,	N. E. WA	SH., DC	20002
	23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Onot e	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	on Conce	r with Meta	stasis		Onset and Death
	resulting in death)  Due to (	or as a consequence of):				
_	Sequentially list conditions, if any, leading to immediate b. Lug	ng metas	tasis with Pla	erural e	fusion	
=	if any, leading to immediate Due to ( cause. Enter Underlying Cause (Disease or injury	or a da consequence of):				
Xall	that initiated events c	JIABETES or as a consequence of):	S MELLITUS			
2						
ב	0.					
n/Medical Examiner		come of pregnancy			23d. Date of deli	very
2	in the past 12 months?	ant at time of death	B Ectopic pregnancy  Other (specify)		Month	Day Year
riiysicia	9 □ Unknown 9□ Unkno	own			1	
5	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Part I.		co use contribute to	
2				1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
combiered by				24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
				performed	death?	
ט מ	25. Was case referred to medical examiner?			ath (Check only one)		
	1 ☐ Yes 25 No Hospital: 1 🛇	npatient 2 ER/Outpat		lome 5 Residence		rify)
	27. Manner of Death 28a. Date of (Mont) 1 ★Natural 5 □ Pending (Mont)	of Injury h, Day Year) 28b. Time Injury	Work?	28d. Describe how i	njury occurred	
	2 Accident investigation	at laine.	M 1 Yes 2 No	204	A   A	-1.0
	determined 286. Flace	of Injury · At home, farm, ng, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	rand Number or Ru late)	rai Houte Number,
	20a Coddiar Continue Physician T. the	host of my keeplades 3-	ath accurred at the time, data and also	and due to the ar-		atatad
5	29a. Certifier Certifying Physician: To the (Check only one) Medical Examiner: On the bit and mani	asis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	s, and due to the caus arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
í	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	, Day, Year)
	Kejal Das gupto		64699	1	9/07	
	30. Name and address of person who completed caus		e Print)		1	
			. 1 .	Dosgun	ota	
9	31. Date filed (Month, Day, Year) 32. R	venue Megistrar's Signatur			<u> </u>	
ır	JAN 23 2007 January	B. Operte				

			For State	State of Maryland		nt of Health and te of Death		7001	03458
			Registrar  1. Decedent's Name (First, Middle, La.	st)	Continua	ic or boair	Reg. N		3. Time of Death
	Physici			MacArthur	Tilah	11010	Month D	)ay 7007	nun 3
	/Medic Examin		Jerome / 4a. Facility Name (If not institution, giv		4b. Cit	, Town, or Location of Dea	th 4	lc. County of Death	
1	CXAIIIII	el	Marketers	exerce //as	pital C	ambrid	6e x	Dorch	ester
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. is	ast birthday) If Und Months	er 1 Year II Under 24 Hrs Days Hours Min		9. Birthi	place (State or Foreign ntry)
	Director		213-44-0214	12M 2DF 6/	Yrs.		Aug. 22,		ryland
1	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
1_	Maryland -f ahow	ō	115 5		ambrid	00			1 ∰Yes 2 □ No
7		ect	10e. Street and Number	ester C		D Code	10g. (	Citizen of What Cou	ntry?
K	within 72 hours after death with the Marylan ene. then "natural", or itema 23a or 28a-f ahow he Madical Examiner must be notified at	Funeral Director	8m Wood	Strant		21/12		115A	
L	death me 2	era	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri Black, White	
9	or ite		1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		2 No Specify:	no moan, etc.,	Specify: // ;	
33	3 2 4	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:				1310	icK_
5-	72 hours "natural",	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's Us (Give kind of y	ual Occupation work done during most of wo use retired)	orking 16b.	Kind of Business/Ir	ndustry
121	within ne ihen	E E	Elementary/Secondary (0-12)	College (1-4or 5+)	A 1 .		(	elf EM	played
2	be filed of tal Hygie		17. Father's Name (First, Middle, Last	)	CIEUNI	ng Service 18. Mother's Na	ame (First, Middle, Maid		1,0469
an	d be antal	o Be	An .	lahman		Beu	lah Mata		
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Le marked other then aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event, the Mental aumatic event even	ြင	19a. Informant's Name/Relationship (		19b. Mailing Addre	ss (Street and Number or F			p Code)
S	nd 2 selfth ar 27 is r trau		Yvonne S	harp	3175h	epard Aven	ue Camb	ridge N	D. 21613
ē,	ges 1 and 2 should be filed within 72 h tt of Heelth and Mental Hygiene. If Itam 27 is marked other then "natu or other traumatic event, the Mudical		20a. Nethod of Disposition		lace of Disposition (Nemetery, crematory of	ame of		Location - City or T	own, State
altimore,	permit. Pages 1 are Depertment of Hee Important: if Item any Injury or othe DECE.		1 12 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	_Hemoval from State	thel CAN	notory 1/	27/07 Ca	Mbridge	MD.
ä	permit. Pag Depertment Important: i any Injury o		21. Signature of Funeral Service Lice		OO Nome	and Address of Facility RY Funeral		3	,
ä	Depe impo		Janelle C	Henry	510 L	Vashinatan	StiCambr	: doe MD	21613
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,	3 /	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Anteson	re legal	@ Heer	Desea	20	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	0 0 0	-		
	Examiner		Sequentially list conditions,	b. End	stage !	Cenel Des	lest		
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	neuce off				
	and and Il-tran	хап	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):				
.09	ite be executed ysicien and ne burial-transit	calE							
687	tificate ig physias the			_ d					
×	eath certifica attending ph for use as th	/We	IF FEMALE:	23c. If yes, outcome of pregna				23d. Date of deliv	very
Box	that the death cert ed by the attendin detached for use	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de				Month	Day Year
P.O.	it the de by the tached	hysi	9 Unknown	9□ Unknown					
σ,	Attanding Physician: The law requires that the death certifical reads. sctor: After this certificete has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	w requires been sign should be	ed to	(eastro in	testeral 121	luding		1 ☐ Yes	2 No 3 Pro	babiy 4 Unknown
ပ္သ	aw requisible s	piet	Pulmones	W embale	sin U		24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
æ	The la	Eo					performed	death?	_
ital	icien: The lav certilicete has rector, page 2	BeC	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
>	ding Physician: The lav h. After this certificete has funeral director, page 2	To	1 Yes 2 No	Hospital: 1 X Inpatient 2 □	ER/Outpatient 3		Home 5 Residence	6 ☐Other (Spec	ify)
0	ng Pt fter th		27. Manner of Death 1 MNatural 5 ☐ Pending	28a. Date Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
Division of Vital Records,	ttendin death. stor: Af	Certification:	2 Accident investigation 3 Suicide 6 Could not l		М	1 Yes 2 No	000 1 (01		
ĕ	or Att	ŧ	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact y)	ory, office	28f. Location (Street City or Town, St		rai Houte Number,
۵	To the Hospital or Attendwithin 24 hours effer death To the Funeral Directors completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge death con-	ad at the time, date and sic	ce, and due to the cause	n(s) and manner as	stated
	Hos 24 ho Fun	Medical	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	tion and/or investigati	on, in my opinion, death oc	curred at the time, date	and place, and due	to the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier			29c. License number		Date signed (Month	, Oey, Year)
	⊢ <b>≤</b> ⊢ ŏ		> Watette	MD		D00633	159 1	121107	7
			30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)			/	
			MAHRUBA AU	HTER, 300	AURORA	STREET,	CAMBRIDO	iE, MD	-21613
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature M.	all 1			
	Banici	2-12	A MENTER AND	I LUUI	The Throng				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 200 7 Month **Physician** January Edgar Van Orden Gerald 1601 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PANIAMAN REGIONAL MEDICAL Willomico 3AUS 6UKU If Under 1 Year | If Under 24 Hrs Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F Months 152-34-3785 63 4, New Jersey Director Feb. 1943 Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Cambridge 1 ☐ Yes 2 No Dorchester MD Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21613 USA 5055 Plantation Road Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2X Married ò 1 ☐ Yes 2 No white Specify: Specify: Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ran portant ovent; the Med any Injury or other traumatic event; the Med ones. Elementary/Secondary (0-12) College (1-4or 5+) agriculture farmer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edgar G. Van Orden Grace Vail ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5055 Plantation Road, Cambridge, MD wife Joyce Van Orden 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Salisbury Crematory 1/19/07 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOXIC PNCE /Medical Due to (or as a consequence of): Examiner yocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to ( r as a consequence of) Examine and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nhknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 30 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of eath 28b. Time of 28d. Describe how injury occurred Injury Natural

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After within 24 hours after death

To the Funeral Director:
completely filled in by the

Baltimore, Maryland 21215-0036

algar Vanoader

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APPNA, M.D. FYANK 400 E. Shore

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

SALISBUM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Patricia /Medical Vinson J<u>anuary</u> 1:38 p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🗓 F 51 Months Director 240-94-9231 Feb. 18, 1955 Northampton, N.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f shov edical Examiner must be notified at Maryland Charles Director Waldorf 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12003 Silver Spur Place Funeral 20601 within 72 hours after death United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary New York State Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Lewis Vinson Bernice Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sambrina Spier/ Daughter 12003 Silver Spur Place Waldorf, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Menola Bapt. Church Jan. 27,2007 Woodland, N.C. 21. Signature of Funeral Service 22. Name and Address of Facility Alexander S. P 5538 Marlboro Pope P.A. Pikė/Forėstville, Md. 20747 Pert1. Ent. r the dis se, or complishions that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anthrown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to initial date cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not psulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 durknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1□ Yes 2 1 No 25. Was case referred to nedical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 \( \sum \) Nursing Home Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day Year) investigation 2 Accident 1 🗌 Yes 2 🗆 No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) d title of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 50454 who completed cause of death (Item 23a) (Type, Print) Arafo Yazdani, M.D. 30. Name and address of ner 3 -41 32. Registrar's Signature State 23 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For AMEND#26 Per PHY. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month January 17, 2007 **Physician** Linda L. Van Heuvelen 1:00 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crownsville Anne Arundel 303 Aston Forest Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept. 124 Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** <sup>Y</sup>°1′937 1 M AFF 69 116-28-2829 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Dapartment of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iteme 23a or 28e-f show enty injury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10b. County 1 Yes 2 No Director Columbus Ohio Franklin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 43201 372 W. 5th Ave. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Decorating Interior Designer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Sofield Clarence Olsen ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Aston Forest Lane Crownsville, MD 21032 Jodi Hernandez (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA. 2007 22. Name and Address of Facility Advent Funeral & Cremation Service M00982 42 Hudson St., Suite 110, Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ca **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the cause in the conditions cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and tor use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 QNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No his certificate has but director, page 2 s 1 Yes 2√No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home Antheridence 6 MOther (Specify) Daughters Home ဥ 1 ☐ Yes 2 ☑ Wo 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Patatural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funerel Directormpletely tilled in by 4 - Homicide 29a. Certifier 1🛱 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title/pf certifier 29c. License number January 17, 2007 DO8118 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) ESTERGE AN ANNAMOUS mo 2140) KIMS STANLEY

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State

Registrar

31. Date filed (Month, Day, Year)

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32.

gistrar's Signature

			For State Registrar	State of	Maryland	•	artment <i>tificate</i>			and M	lental Hy	giene Reg. No.	007	034	62
	Dhysisia		Decedent's Name (First, Middle,	, Last)							2. Date of De Month	eath Day	Year	3. Time of	
	Physicia /Medic		Mary H. Wilso							( D )	Januar			3:05	РМ
	Examin	er	4a. Facility Name (If not institution, Anne Arundel Me				4b. City, 1		Location of			4C.	County of Dea Ann	™ e Arund	el
7	Funeral			6. Sex	7. Age (In yrs. la	st birthday)	If Under 1	1 Year	If Under	24 Hrs.	8. Date of Bi (Month, D	rth		thplace (State o	
	Director		215–56–8279	1 □ M 2 <b>XX</b>	57	Yrs.	Months	Days	Hours	Min.	Dec. 2	4, 19	49	Marylan	d
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Lo	cation							10d. Inside C	ty Limits
	Manyli f sho	ţŏ		Arundel				I	Annap	olis	5			1 <b>∑</b> Yes	2 🗌 No
	or 28a	Funeral Director	10e. Street and Number				10f. Zip		21401			10g. Citi	zen of What C		
	a 23a	ral	31 City Gate La		dent Ever in U.S	12.1	Maa Daaadi			ain? (Sa	acify Vac or N	0-	14. Race - Am		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic svent, the Modical Exacilinar, native notified a once.	by Fune	11. Marital Status  1 □ Never Married 2 ★ Marri 3 □ Widowed 4 □ Divorced	Armed For	rces? <b>2/03/N</b> o e	1	f Yes, speci		Specify:	i, Puerto	ecify Yes or N Rican, etc.)		Black, Whi	te, etc.	
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7	Hygier Hygier ther th	e Co	12 17. Father's Name (First, Middle, I	Last)			Paral	Lega.		or's Name	e (First, Middle	, Maiden	Law Sumame)		
yland	id be ental ked o	To Be	Joseph F. Holl		7.					Imc	gene H	arper			
Mary	shou and M s mar		19a. Informant's Name/Relationsh										r Town, State.		
Σ,	and 2 ealth m 27 I		William Wilson	n/husband	20h BI						napoli:		ryland		
Baltimore,	ages 1 of H or of H:		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		State	ace of Dispo									3
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	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):													
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ב.	res that t igned by be deta	by Ph	Part II. Other significant condition	ens contributing to de	eath but not resu	ılting in the u	ndertying ca	ause give	n in Part I		23e. Did	tobacco u	se contribute	to the cause of	death?
rds	w requires been sign should be		previo	us Luil	y Cau	icen					1)×	Yes 2	□No 3□F	Probably 4 🗆	Unknown
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lon	ath. rr: Afte	atlo	1 Natural 5 Pendin Pendin Pendin investig	ation	th, Day Fear)	Injury	М		Yes 2	No					
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	not be ined 28e. Place buildi	of Injury - At hoing, etc. (Specify	me, farm, st	reet, factory	, office				(Street an own, State		Rural Route Nun	nber,
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		_	For State Registrar		State of	Maryland		artment rtificate					giene Reg. No.	007	03463
3	Physici	30	1. Decedent's Name (First, Midd	le, Last)								<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
4	/Medic	_	Dorothy M.	Wall								January		2007	6:15 A M
	Examin	er	4a. Facility Name (If not institution					4b. City, 1		Location of	of Death			ounty of Deat ne Arul	
			Crofton Conva.  5. Social Security Number	6. Sex		Cer Age (In yrs. Ia	ast birthday)	If Under		fton If Under	24 Hrs.	8. Date of Birt	h	9. Birt	hplace (State or Foreign
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		-	Usual Residence of Decedent												
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	with ti	급	10e. Street and Number					10f. Zip		1.1				n of What Co	unity:
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036	ursal	þ	3 Widowed 4 Divorce		If Yes, Give Year or Date			1 ☐ Yes 2	. □ <b>X</b> 40	Specify:			S	pecify: W	hite
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Z	od 2 s lith ar 27 is r trau		Jonathan T. Wa			ıse		Eton				, MD.	2111		
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition			20b. PI	lace of Dispo emetery, crer	sition (Nam	ne of	e)	D	ate	20c. Loca	tion - City or	Town, State
9	Page eent o nt: if ry or		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		emoval from St	ate					01/24	/2007	Davi	dsonvi	lle, MD.
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Sepries	License	θ	01		2. Name an				11 Fund		_	
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14	Physician		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition	r complic t only on	cations that cause on each	ch line.	n. Do not ent	ter the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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9	ifficati g phy as the				•										
Вох	eath certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant	2:	3c. If yes, outco	ome of pregnath 2 Petal		⊒Ectopic pr	eonancy				23	d. Date of de	•
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ecc	law re as be 2 sho	Completed										24a. Was	an	24b. Were at	utopsy findings available completion of cause of
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Θ	s after s after of in b	Certification:	4 Homicide	mined	building	g, etc. <i>(Specif</i> )	y)					City or To	wn, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical (			sician: To the base and manne	sis of examinat									s stated. e to the cause(s)
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	· ·	o to	Heidi Townsen 31. Date filed (Month, Day, Yea		1.D. _32.Re	1684 gistrar's Signa	VILLac	ge Gre	en	C	TOLLO	on, MD.	211	14	
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		-	For State Registrar	State of M	aryland		artment tificate			and M		giene Reg. No.	007	03464	
F			1. Decedent's Name (First, Middle, L.	ast)							2. Date of De Month	ath Day	Year	3. Time of Death	
	Physicia /Medic		GLORIA	WILL	IAMSO	N					01	21	2007	5:45 A M	
	Examin		4a. Facility Name (If not institution, gi						Location of	of Death			County of Dea		
-		3	Heartland of Ad					elphi		Od Man				Georges	
ŀħ,	Funeral			Sex 7. Ag 1 ☐ M 2 🖸 F		ast birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	v. Year)	C	rthplace (State or Foreigr ountry)	1
	Director	-	147-16-3119 Usual Residence of Decedent		84						Aug. 9	, 192	zz New	Jersey	
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	
	Mary -1 sh	ţ	MD Prince	Georges	Mit	che11	ville							1 ☐ Yes 2 No	
	7 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What C	ountry?	
	death with the Maryland oms 23e or 28e-1 show or must be notified at	a D	2114 Bermondsey	Dr.			2	0721					USA		
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Deced	lent of His	spanic Ori	igin? (Spe	cify Yes or No Rican, etc.)	)-	14. Race - Am Black, Wh		
٥	or Ite	교	1 Never Married 2 Married	1 ☐ Yes 2 🔯 If Yes, Give			1 ☐ Yes 2	5.0	Specify:				Specify:		
ž	n 72 hours after death with the Marylar "neturel", or Items 23e or 28e-1 show adicel Examirer must be rigified at	d by	3 AWidowed 4 ☐ Divorced	Year or Dates:								105 165	d of Brown and	Black	
9500-61212	filed within 72 ho I Hygiene. other then "neturent, Ibe Madical	Completed	15. Decedent's l (Specify only highest g			16a. Dece (Give	kind of woi DO NOT us	k done d	uring mos	t of work	ng	160. KII	nd of Business	windustry	
7	withli ene. then	d L	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		stere					St.	Elizab	eth Hospita	1
	filed Hyg othe ant,	ပိ	17. Father's Name (First, Middle, Las							er's Name	(First, Middle				
<u>a</u>	od a b	To Be	James Percy Thor	nton					Fan	nnie	Payne				
Maryland	s 1 and 2 should by Health and Meni them 27 is marked them 27 is marked other traumatic		19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a	ind Numbe	er or Rura	Al Route Numb	er, City o	Town, State,	Zip Code)	
	is 1 and 2 of Health a Item 27 is		James M. William	nson/Son		Mitc	<u>hellv</u>	<u>ille</u>	, Md.	207					_
Se	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	20b. P	lace of Dispo emetery, crea	sition (Nan natory or o	ne of ther place			Date	20c. Lo	cation - City o	r Town, State	
Ĕ	Pages ment of ant: If It ury or o		4 Donation 5 Other (Spec		Ar1	Lingto	n Nat	iona		2-6-2			ington,		
Baltimore,	permit. Pages 1 Department of H Important: If Itel any injury or ott		21. Signature of Funeral Service Lic	1/1 160	100	2					shall's				
	₹0 E € 0		7. 7.11	ursna	w						Washir		., 0.0.	Approximate	
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	by one cause on each	line.				g, such as	cardiac	or respiratory a	irrest,		Interval Between Onset and Death	
8	/Medical Examiner		resulting in death)	Due to (or as											
		16	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Coronar	ry Art	tery D	iseas	e							
	petri f insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
a r	be executed ician and burial-transit	Еха	resulting in death) Last	Due to (or a:	s a consequ	uence of):									
760,	e X e	icai	,	d											
89	it the death certifica by the attending ph tached for use as it	Med	IF FEMALE:		5783										
Box	ath ce ttendi	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	Ideath 3	Ectopic pr					1	23d. Date of de Month	elivery Day Year	
o.	the a	Physician/Med	1 ☐ Yes 2X No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	at time of de	eath 5L	Other (sp	өсіту)							
<u>a</u>	that the		Part II. Other significant conditions	contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I	l.	23e. Did	tobacco u	se contribute	to the cause of death?	
g	w requires that s been signed t should be deta	d by	End Stage Rena	al Disease							1 🗆	Yes 2[	] No 3 ☐ F	Probably 4000Unknown	1
<u> </u>	w req	Completed	Peripheral Vas		ease						24a. Was		24b. Were a	autopsy findings available	9
Re	The lav	omp	reripiterar va.	Jeanar Dist					-		auto perf	ormed?	prior to death?		
a	sician: The la certificate ha irector, page 2	BeC	25. Was case referred to medical						26. Place	e of Deat	h (Check only				
<u>=</u>	ysician: nis certifica director,	ToB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpat	tient 2	ER/Outpatie	nt 3 DC	Othe Othe	97: 4X N	ursing Ho	me 5 Res	idence (	6 □Other (Sp	ecify)	
0	9 Pt		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time o		28c. Injury Work			28d. Describe	how intur	y occurred		
<u>S</u>	teath. leath. tor: A	cati	2 Accident investigat 3 Suicide 6 Could not	he			М		Yes 2	No	CD4 1ti	/C+	d 8 (1 m) h = 1 m = 1	Devel Devile Manha	
Division of Vital Records,	al or Attendin atter death. I Director: Aft d in by the fur	Certification:	4 Homicide determine	288. Place of it	njury - At ho atc. <i>(Specif</i> )	ome, farm, st	reet, factory	y, office			City or To			Rural Route Number,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 To Certifying (Check only one)	Physician: To the bes aminer: On the basis and manner s	of examina	wiedge dear	h occurred westigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(s) date and	and manner and di	as stated. ue to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and little of certifier				290	c. License	e number	/ 1	1	29d. Dat	e signed (Mo	nth, Day, Year	
									5	61	4/		112	210/	
)	, 114)		30. Name and address of person wh					m 1		V ( "	M1 0	0010	1 00	-   /	
			Nasreene Kang	0, M.D. 7	610 Ca	arroll	Ave	Tak	oma	rark	, Md. 2	0912			
**************************************	Sta Regist		JAN 2 4 2007	Serem 1	1. A	out							-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death Date of Death **Physician** Month Day BARRINGTON DONALD WILSON 18 2007 JAN. 11:55 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. | 2, 1948 Laurel Regional Hospital PRINCE GEORGES 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 S M 2 □ F Jamaica Yrs 58 **Director** 579-11-7960 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Director MDPr. Geo. Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 15459 Arbor Way 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify Black þ Specify: 3 Widowed 4 Divorced "natural" Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Macy's Department Elementary/Secondary (0-12) College (1-4or 5+) the Tailor 6th Store other atth and Mental Hy. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beris Ford Wilson Josephine Baker White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 Health a 316 Wye Mill Ct. Gaithersburg, MD Susan Wilson Redwood (Daughter) If item 2 or other Pages 1 ament of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department c Important: If any Injury or once. Gate of Heaven Cem 1/26/07 Silver Spring, MD 21. Signatural f Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ear 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Coagulopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Acute Renal Failure physician and sthe burial-trans Due to (or as a consequence of): Physician/Medical Cirrhosis of Liver nding pl IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown GI Bleeding; Hepatic Encephalopathy Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed' **2√** № 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1X Natural 5 Pending after death.

Director: A
d in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

The law requires that the death certificate be executed Ö ٦ Division or Vital Records, or Attending To the Hospital within 24 hours a To the Funeral I

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

completely

Medical

Day, Year) 31. Date filed (Mo

Mish

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

M.D. 7300 Van Dusen Rd, Laurel, MD 20707 Mythily Vancha, egistrar's Signature

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064760

29d. Date signed (Month, Day, Year)

1/18/07

			For State	State of M	aryland /		artment of H		nd Me	ental Hyg	giene	(m) mm	00100	
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cei	tificate of I	Death		P. Date of Dea	Reg. No.	U/	3. Time of Death	
20	Physic -/Medi		JOHN	WALTER		WH	ITMAN			Month January	Day	) Year	9:00 A M	
1	Examir		4a. Facility Name (If not institution, gi	,			4b. City, Town, or				4c. County	of Death	1	
,,	*************		19313 Treadway  5. Social Security Number 6.		ge (In yrs. last b	irthday)	Brooke	V1IIe	1 Hrs. I g	R Date of Birth		ntgon	nery  place (State or Foreign	
	Funeral Director		368-40-0353	1 <b>X</b> M 2□F	66	Yrs.	Months Days		Min.	B. Date of Birth (Month, Day May 15	1940	COL	chiqan	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation						10d. Inside City Limits	
	Maryl a-f sho filed a	tor	Md. Monte	gomery	]	Broo	keville						1 □ Yes 2 No	
	or 28	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizen of V	What Cou	untry?	
	eath v 1s 23a must	Funeral	19313 Treadway :	Road 12. Was Decedent	Ever in U.S.	13.1	208		n2 (Speci	fy Vos or No			tates ican Indian.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Fun	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ★ Yes 2 ☐ If Yes, Give Year or Dates:		_	Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2 2 No	Specify:	Puerto Ri	can, etc.)		ck, White		
2-0	72 hor	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		a. Deced	lent's Usual Occupa	ation during most o	of working		16b. Kind of Bu	usiness/lı	ndustry	
21215-0036	within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or s	5+)	life. I	oo NOT use retired rt Report	)	, working		Lega	al		
Maryland 2	should be filed wind Mental Hygies marked other tumatic event, the	Be	17. Father's Name ( <i>First, Middle, L</i> as Benjamin Whitm	<i>'</i>				18. Mother's Sign		First, Middle, I	Maiden Surnan	1e)		
aryl	2 should be fi and Mental H is marked ot raumatic ever	To	19a. Informant's Name/Relationship	(Type. Print)	19	b. Mailin	g Address (Street a	and Number o	or Rural I	Route Number	r, City or Town,	State, Zi	ip Code)	
	1 and 2 Health em 27 I		Diane C. Whitman	n / Wife			3 Treadwa	y Road			<u>-</u>		20833	
nor	0 0		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 [  4 ☐ Donation 5 ☐ Other (Spec		cemete	ery, cren	sition (Name of natory or other place itan Cren	i i	Dat 1/22		20c. Location -	•	,	
Baltimore,	permit. Page Department o Important: If any Injury or once.		21. Signature of Funeral Service Lice		leo-	22	Name and Addres	s of Facility Barbe	er Fi	uneral	Home		•	
91			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition	a Pros	take	C	encer						Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):								
	49	Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. — Due to (or as	a consequence	of):						-		
	ecuted and -transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	cate be executed oblysician and the burial-transit	dical E		Due to (or as	a consequence	· OT):								
9	8 주는	Medic	JE SERVICE	0.										
.O. Box	The law requires that the death certifit to has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deatl		Ectopic pregnancy Other (specify)		_		23d. Dat	te of deliv	rery Day Year	
Δ.	res that signed by be deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the un	derlying cause give	n in Part I.		23e. Did tob	pacco use contr	ribute to t	the cause of death?	
ord	w require been sig should b	ted t							_	1 □ Y€	es 2 No	3 Prol	bably 4 Dinknown	
or Vital Records,	. @ 🖸	Completed							_	24a. Was ai autops perforr 1□ Yes 2	med2/	Were auto prior to co death? I ∐Yes	opsy findings available ompletion of cause of 2 ☐ No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			3CLDOA Othe	p.		Check only on				
۰ ر		n: To	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	3 DOA 28c. Injury Work	4 LI Nursii			ence 6 Other		fy)	
sior	ten eat tor: the	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	n		Injury	M   1 □ Y	: ′es 2∐No						
=	i Pi fi	Certification:	4 Homicide determined		ury - At home, fa c. <i>(Specify)</i>	arm, stre	et, factory, office		28f	Location (St. City or Town		er or Rura	al Route Number,	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	t examination ai	e, death	occurred at the tim restigation, in my op	e, date and p pinion, death	place, and occurred	d due to the ca at the time, d	ause(s) and ma ate and place, a	nner as s and due t	stated. to the cause(s)	
		Me	29b. Signature and title of certifier	0			29c. License			25	9d. Date signed	(Month,	Day, Year)	
<b>)</b>	(0+1		Juliane Who	W W	)	(T	0006	4615			1/22/	107	7	
			30. Name and address of person who Genevieve Wrobl	ewski, M.D	. 135		orint) .ccard Dri	ive, #:	100,	Rockvi	ille, Mo	d. :	20850	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 23 2	007 32. egistra	ar's Signature	do	and a							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month January 18, 2007 2:15 p M Whittington, Jr. Luther Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 14,1917 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Maryland Director 577-26-1864 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Directo MD St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mentral Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or. amy hjury or other traumatic event, the Medical Examiner must be rone. U.S.A. 21585 Peabody Street 20650 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify. þ white 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 grocery store owner retail grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Augusta Catterton Luther Edward Whittington, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 907, Lusby, MD 20657 Mary Whittington Gott, daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) So. Memorial Gardens 01/23/2007 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. e of Funeral Service Libenses 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line. death. Do not enter Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of Jory, a Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, anding p. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate ha irector, page 2 performed' or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: မ 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural (Month, Day Year) Injury after death.

I Director: A
d in by the fu 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the back of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title

30. Name and address

James P 31. Date filed (Month, ertifier

JAN 23

se of death (Item 23a) (Type, Print) 24035 Three Notch Rd.,

29c. License number

Hollywood, MD 20636

29d. Date signed (Month, Day, Year)

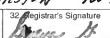
#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Yea **Physician** Month Day Lillian Dell Worthington JANUM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PENINSUA KEGIONOL MEDICOL Hiemica SALISBUM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 23, 1915 Jirthplau Country) NC 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2**X**) F Director 242-18-8140 91 Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notffied at 10d. Inside City Limits Director Worcester 1 □X es 2 □ No Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or a 10526 Harrison Rd. 21811 USA Funera! Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: \$ Specify: Black 3 Widowed 4 ☐ Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Various Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Wilson Estella Pollard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Gloria Blake/daughter 9745 Hotel Rd., Bishopville, MD 21813 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or 4 □ Donation 5 □ Other (Specify) New Bethel UMC Cem 1/25/2007 Berlin, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD attota 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2**X** No 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To **?**✓ No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one)

24 hours after death e Funeral Director: To the Fun completely the

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUdalleston

JAN 23 2007

29b. Signature and title of certifier



SALISBUM

29c. License number

29d. Date signed (Month, Day, Year)

	4	For State Registrar	State of Ma	ıryland	•	irtmen <i>tificat</i>			d Me		eg. No.	200	7 03	3469
	_	1. Decedent's Name (First, Middle, La	ist)						2	Date of Dea Month	th Day	Yea		e of Death
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amine	er	4a. Facility Name (If not institution, give		A.	1.1	4b. City,	Town, or	Location of D	eath	,	4c. (	County of De		
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eral			Gex 7. Age 1 ZMM 2 □ F	(In yrs. 18	st birthday) Q Yrs.	If Under Months	Days		lin.	Date of Birth (Month, Day	, Year)		lirthplace (Sta Country)	
ctor	-	213-22-7238 Usual Residence of Decedent			0				N(	ov. 26	, 19	28	MARYLA	AND
14		10a. State 10b. County		10c. City	Town or Loc	cation			-				10d. Inside	e City Limits
Pel	ا ف	MARYLAND WICOM	ICO	W	ILLARD	S							1 🔯 🗎	Yes 2 □ No
tout	Directo	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	en of What	Country?	
4	ᡖ	36326 REGINAULT	ST.			2	1874					USA		
the Medical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	6. 13. V	Vas Deced	dent of His	spanic Origin?	(Specif	y Yes or No-	1	4. Race - An Black, Wi	nerican Indiar	n,
를	린	1 ☐ Never Married 2 🕅 Married	1 MTYes 2 □ N	0		Yes		Specify:		,		Specify:		
Ex	d b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1945	-4 /								WHITE	
g	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	lent's Usua kind of wo DO NOT us	rk done d	uring most of	working		16b. Kin	d of Busines	ss/Industry	
2	ם	Elementary/Secondary (0-12)	College (1-4or 5-	+)			,	JPERVIS	OR		ST	ATE HI	GHWAY	
- ·		17. Father's Name (First, Middle, Last	')					18. Mother's I		First, Middle, I				
) O	To Be	GEORGE E	DWARD	WTT.	KINS			ANNI	E	GER'	rrud'	E	BAKEF	₹
mati	-	19a. Informant's Name/Relationship		****		a Address	(Street a	nd Number or						
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othe	1	20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Nar	ne of	1	Date	1.41			or Town, State	
-		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	LE CEMI	•			23/0	7	WHAT	.EYVII.	LE, MA	RYT.AND
eny injury o obce.	T	21. Signature of Foneral Service Lie		DILL				s of Facility	2370		WILLIAM	IDI VIII.	DD, 141	ICI HILICO
o do		1/2/2/2 /10	24.1	-	HA	STIN	GS FU	JNERAL	HOM	E, SELI	BYVI	LLE, I	E. 199	975
	Exam	Sequentially list conditions, if any calling it immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b.  Due to (or as a c.  Due to (or as a d.	consequ	ence of):								hours	<b>S</b>
ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 24□Pregnant at 19□Unknown	2 Fetel	death 3□	Ectopic pr Other (sp					2:	3d. Date of d Month	lelivery Day	Year
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2	ğ								-	24a. Was a autops	v	24b. Were prior to	autopsy findir o completion	ngs available of cause of
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	Be	25. Was case referred to medical examiner?	Managhali, 1979				1.04		Death (0	heck only on	Θ)			
5	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatier		R/Outpatient			4   Nursin		5 🗆 Reside			oecify)	
1905	ü	27. Manner of Death 1 ANatural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year)	28b. Time of Injury		8c. Injury Work		280	I. Describe ho	ow injury	occurred		
	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2 □ No						
6	Certification:	4 Homicide determined		ry - At hor . (Specify)	ne, farm, stre	eet, factory	y, office		28f	Location (Si City or Town	reet and n, State)	Number or i	Rural Route N	Vumber,
completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying P	hysician: To the best o miner: On the basis of and manner stat	examinati	rledge, death on and/or inv	occurred	at the time, in my op	e, date and plainion, death o	ace, and	I due to the ca at the time, d	ause(s) a ate and p	and manner and di	as stated. ue to the caus	se(s)
complet	₩.	29b. Signature and title of certifier				290	c. License	number		2	9d. Date	signed (Moi	nth, Day, Yea	r)
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R		30. Name and a less of person who	completed cause of de	ath (Item	23a) (Type. F	Print)	11006	453-1		-	11 ~	,9101	_	

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar		of Marylar	nd / Depa		t of H	ealth a	and M	lental Hyg	iene	07	031	+70
	Dhusisi		1. Decedent's Name (First, Midd	le, Last)							2. Date of Deat Month	th Day	Yeer	3. Time o	
	Physicia /Medic		Earl Kim Wate	rs							Jan	_19	2007	3:00	) A M
	Examin	er	4a. Facility Name (If not institutio	n, give street and n	umber)				Location of	of Death			ty of Death		
_			507 Hearn Lane 5. Social Security Number	6. Sex	7. Age (In yrs.	last histodayl	Sa If Under	lish	oury If Under	24 Hrs	9 Date of Righ		Vicomio		or Foreign
	Funeral Director		216-70-1989 Usual Residence of Decedent	1⊠M 2□F	49	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 1,	<sup>Year)</sup> 1957	Coun	lece (State try)	or r oraigir
	be filed within 72 hours after death with the Maryland ital Hygiere. d other than "natural", or items 23a or 28a-f ehow event, it a Medical Examinar must be notified at		10a. State 10b. County			ty, Town or Lo						·	1	Od. Inside C	
	e Ma	cto	MD Wico	mico	Sa	alisbur									2 □ No
	vith th	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen of		try?	
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_	ter de	Ľ.	11. Marital Status 1 □ Never Married 2 ☑ Mar	Armed F	orces?	13.	f Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	Bla	ack, White,	etc.	
2	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, the Medical Examinat must be notified at	by	3 Widowed 4 Divorced	If Yes, G	ive		1 ☐ Yes 2	2X No	Specify:			Spec	ity: Blac	ck	
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V	vithin ne. hen.	Idm	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT us					a			
V	illed v Hygie ther t nt, in		12th 17. Father's Name (First, Middle,	Last)		<u> </u>	Sup	ervi		er's Name	(First, Middle, M		ood Co	mpany	<i></i>
200		To Be	Earl Henry Wate								ne Gatti		,		
	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address	(Street a	und Numbe	er or Rura	al Route Number	, City or Town	n, State, Zip	Code)	
Ž	and 2 valith a 27 is		Karen L. Water:	s/wife		507 H	earn	Lane	, Sal	lisbu	ry, MD	21801			
	of He of He If item		20a. Method of Disposition  1 Burial 2 Cremation	3 □Removal from	20b. i	Place of Dispo cemetery, crer	sition (Nam natory or of	ne of ther place	9)	[	Date	20c. Location	n - City or To	wn, State	
	Pag ment tant:		*4 □Donation 5 □ Other (\$	Specify)	Gre	en Acr					2007	Salis	bury,	MD	
Dallimor	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service			L	. Name an	N. W	atsor	า Fur	neral Ho	me			
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	Physician /Medical		23a. Part <sup>1</sup> . Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Me		c Car					ecto ~			Interval Be Onset and	Death
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N II a		e C	25. Was case referred to medica	al					26. Place	of Death	1 Yes 2	e)	1 1 1 1 1 1 1 1	2 140	
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0 10	or Attending Physician: ther death. Director: Atter this certific in by the funeral director.		27. Manner of Death  1 Natural 5 Pendi 2 Accident invest	28a. Date (Mo igation	of Injury nth, Day Year)	28b. Time of Injury	M 2	Bc. Injury Work 1 🔲 Y	at ? /es 2 🔲		28d. Describe ho	w injury occu	urred		
DIVISION	for Atter after dea Director	ertification;	3 Suicide 6 Could 4 Homicide determ	nined 286, Piac	e of Injury - At h ding, etc. (Speci	ome, farm, str	eet, factory	, office			28f. Location (St. City or Town		nber or Rura	Route Nur	nber,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After i completely filled in by the funeral	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or in	occurred a	at the tim in my op	e, date an pinion, dea	id place, th occurr	and due to the ca ed at the time, da	ause(s) and nate and place	nanner as st	ated. the cause(	s)
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	100		30. Name and address of person		_	m 23a) (Type,	Print)	- A	Car	-10/1	5t.				10
	Sta	te	31. Date filed (Month, Day, Year		Registrar's Sign	ature								1	
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	nd / Depa	artmen		Mental Hyg	•	03471			
			1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death			
	Physici /Medi		George Wesley	Warfield				January		8:00 a.M			
1	Examir		4a. Facility Name (If not institution, give s				Town, or Location of De	ath					
			702 Smith Stree				Salisbury		Wicomico				
	Funeral Director		5. Social Security Number 6. Sex	M 2□F	. last birthday) Yrs.	If Under Months		n. (Month, Day,		place (State or Foreign intry)			
			215-40-3259 Usual Residence of Decedent	6	5			Jan. 12	, 1942 Mai	ryland			
	ylanc how		10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits			
	Sa-f	Ş	MD Dorches	ster		(	Cambridge			1 ☐ Yes 2 ☑ No			
)	it to	Director	10e. Street and Number	1		10f. Zip		10	og. Citizen of What Cou	intry?			
	a 23e	rai	895 Hudson Road		11.5		21613	(0	USA				
_	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in the Armed Forces? 1 X Yes 2 □ No	J.S. 13.	If Yes, spe	dent of Hispanic Origin? cify Cuban, Mexican, Pu	erto Rican, etc.)	14. Race - Amer Black, White				
20	urs af	Ď	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates: 195	9-63	1 🗌 Yes	2  No Specify:		Specify: W	nite			
5	be illed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or itema 23a or 28a-f ehow evant, the Medical Examinal must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usu	al Occupation ork done during most of w	nduna	16b. Kind of Business/Ir	ndustry			
N	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)	orang					
Baltimore, Maryland 21215-0036	e filed within al Hygiene. I other than '		12 17. Father's Name (First, Middle, Last)			techi	nician	and Cina Middle A	fuel compa	any			
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Ž	should be nd Menta i marked imatic ev	2	19a. Informant's Name/Relationship (Ty)		19b. Maili	na Address	(Street and Number or			n Codel			
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ā,	permit. Pages 1 and 2 should Department of Heelth and Mer Importent: if Item 27 is marke any injury or other traumatic ADGS.	100	20a. Method of Disposition	206.	Place of Dispo	sition (Nar	me of		20c. Location - City or T	own, State			
Ē	Page nent o nt: if ny or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			rans Cem. 1	/25/07	Hurlock, MI	)			
<u>=</u>	permit. Departm Importe any inju		21. Signature of Funeral Service License				nd Address of Facility		neral Home	P.A.			
מ	88 = 8	1 1	15-k.15			700 L	ocust St., (	Cambridge,	MD 21613				
	Physician /Medical Examiner  portial-transit  physician and physician and physician and physician and physician are provided to the physician and physician are provided to the physician	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	er				Onset and Death			
. Box 68	death certifica e attending ph od for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	I.  3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	⊒Ectopic pi ⊒ Other (sp			23d. Date of delive Month	ery Day Year			
	The law requires that the ste hes been signed by th page 2 should be detache	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying o	ause given in Part I.		acco use contribute to l s 2⊠No 3⊟Pro	the cause of death? bably 4 Unknown			
		Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to co	opsy findings available impletion of cause of			
2 .	iclan: Th certificete ector, pag	a	25. Was case referred to medical examiner?	lospital:				eath Check only one		daughters			
5 6	Phys this ral dii	tion: To	27. Manner of Death 1 ⊠Natural 5 □ Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury		OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	Home 5 Reside	nce 6 <b>A</b> Other (Speci w injury occurred	home			
DIVISI	Hospital or Attanding 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, sti ify)			28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,			
	the Hospital thin 24 hours a the Funerel i mpletely filled	ledical C	29a. Certifier 1 ont yin, Physical Check only 2 Medical Examination	sician: To the bast of my kn ter: On the basis of examin and manner stated.	owledge deal ation and/or in	n secured vestigation	at the time, date and pla , in my opinion, death oc	ne, and oue to the ca curred at the time, da	usa(e) and manner as e ite and place, and due t	tated o the cause(s)			
	To the Comple	Me	29b. Signature and little of certifier			290	t5049	29	ed. Date signed (Month,	Day, Year)			
			30. Name and address of person who co	( 100 E.	amil	St.	Sai	why m	0 2(80)				
1	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	bou	W .	J					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend items 10a-c e f 17.18 per inf e865 3-9-07 vt State of Maryland / Department of Health and Mental Hygiene, Commonwealth 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:30 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.
Months Days Hours Min IAN OMI MAR Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2□ F 14-60-98 Yrs. Director Usual Residence of Decedent 10a. State KS 10b. Count Sedgwick 10d. Inside City Limits death with the Maryland 10c. City, Town or Location iral, or items 23a or 28a-f show Examiner must be notified at Wichita 1KYes 2 No Director 67207 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8929 E. Blake Ct. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Dayes 2 Do 973 Hyes, Give Year or Dates: 992 14. Race - American Indian, Black, White, etc. 11. Maritat Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical Department of Health and Mental Hygiene important: If Item 27 is marked other than any injury or other traumant. Elementary/Secondary (0-12) College (1-4or 5+) TEM 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fatter som Einst, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Veterans Com 22. Name and Address of Facility BENNIE 23a. Part1. Enter the disease shock, or heart failure. e, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ance **Physician** Metastaln /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriging Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetat death in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? this certificate has 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Pescribe how injury occurred 27. Manner of Death Certification: After Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 🗌 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 126278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salish Costal Hospin 02411

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Reg. No. 0 0 7 0 3 4 7 3
ı	Physici		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 7. 2155 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Johns Hopkins Bay view Medical Center 15a Timore City
	Funeral Director		5. Social Security Number 212-72-1093 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 6. Sex 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 7. Age (In yrs. last birthday) 1t Under 1 Year 1t Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 43 Yrs. 8. Date of Birth (Month, Day, Year) 44 Yrs. 8. Date of Birth
	Maryland -f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits           MD         Kent         Still Pond         1 □ Yes 2 ☒No
	h with the 23a or 28a at be nuti	al Direc	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  26721 Dutchtown Rd.  21667  U.S.A.
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Exertimetration and injury or other treumetic event, the Medical Exertimetration of the rediffical and once.	by Funeral Director	11. Marital Status  1
21215-0036	ed within 72 ho giene. er than "netu t, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Disabled  16b. Kind of Business/Industry Mentally Hanicapped
Maryland	ould be file Mental Hy varked oth	To Be (	17. Father's Name (First, Middle, Last)  James Harry White  18. Mother's Name (First, Middle, Maiden Sumame)  Dorothy Middleton
	1 and 2 sh Health and em 27 Is rr ther treum		19a. Informant's Name/Relationship (Type, Print)  James H. White (father)  P.O. Box 40 Still Pond, MD. 21667  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	it. Pages intment of I intent: If it injury or o	,	1 \( \text{XBurial 2 \( \text{Cremation 3 \( \text{Removal from State } \) Chestertown, MD. \( \text{YDonation 5 \( \text{Other (Specify)} \) Chestertown, MD. \( YDONATION 1 \( \text{CREMETERY 2 \( \text{Y \) 1 \( \text{YDONATION 1 \( \text{YDONATION 2 \\  \text{YDONATION 2 \( \text{YDONATION 2 \( \text{YDONATION 2 \\  \text{YDONATION 2 \
Ba	permi Depar Impor any ir		M00510 Galena Funeral Home of Stephen L. Schaec 118 West Cross St. Galena, MD. 21635
	Physician /Medical Examiner		23a. Pam. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Approximate Interval Between Onset and Death Onset and Death
8760,	death certificate be executed e attending physician and tor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cit sacs of rither) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):
.O. Box 68	D 0 D	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) Month Day Year 9 □ Unknown
Records, P.	The law requires that the ste has been signed by the bage 2 should be detache	ted by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Scizure disordor, Chronic respiratory  1 yes 2 to 3 Probably 4 Unknown
al Reco		Completed by	Tailure Iracheos Iony  Mental retardation  24a. Was an autopsy prior to completion of cause of death?  1 yes 2 No 1 yes 2 No
of Vital	Physicien: r this certificated director,	To Be	25. Was case referred to medical examiner?  1   Yes   2   No
Division	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manner of Death  1 XNatural  2 Accident  3 Suicide  4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  1 Yes 2 No  28c. Injury at Work? M  1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred
	he Hospitk n 24 hours he Funeral pletely filled	Medical C	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	To th To th	Ž	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  1/31/07
_	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 505 Hophing Tay View Circle W. 15. Orce Nough Mit Mo 15g IT in one MS 21-224
	Sta Registr		FEB 0 6 2007  Registra's Signature

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			1 - For State Registrar	of Ma	-		ent of Health and ate of Death	, ,	iene 2007	03474
	Physici	an	Decedent's Name (First, Middle, Last)			-		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Donald Clarence Whe					Januar	117 200	
	Examir	ner	4a. Facility Name (If not institution, give street and Dorchester General	2	Hospita	L 46.0	ity, Town, or Location of De Cambrid	9e	4c. County of Deat	1
1	Funeral Director		5. Social Security Number 6. Sex 1213-24-0504 12/M 2		(In yrs. hast birti 78 Y	hday) If Un Mont	der 1 Year If Under 24 H hs Days Hours M		, 1928 Mar	hplace (State or Foreign LyTand
-	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	deeth with the Maryland ms 23a or 28a-f ehow	ctor	Maryland Dorchester		Cam	bridge				1 ☐ Yes 2 ☐ No
03	with the sor 28	Funeral Director	10e. Street and Number 215 East Appleby Aven	110		10f.	Zip Code 21613	10	0g. Citizen of What Co	ountry? USA
Sh	deeth	nera	11 Marital Status 12. Was I	Decedent Ev	ver in U.S.	13. Was De	ecedent of Hispanic Origin? Specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Ame	rican Indian,
778	urs after al', or ite	5	1 Never Married 2 Married 1 PY	Forces? es 2 □ No Give or Dates:1 ⊆	。 955 <b>-</b> 57		s 2 No Specify:	erto Hican, etc.)	Black, White Specify:	white
3.00	"natur	eted	15. Decedent's Education (Specify only highest grade complete	ed)	16a. I	Decedent's U	Isual Occupation work done during most of v T use retired)	vorking 1	16b. Kind of Business/	Industry
7. 21215-0036	d withir	Completed	Elementary/Secondary (0-12) Collect	je (1-4or 5+	-1 1 -		e Operator		Wire Clo	oth
and Canada	permit. Pages I and 2 should be tiled within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination at the multiple at Ance.	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Harley Wheatley					<sub>lame (First, Middle, M</sub> race Wheel		
Man	and 2 sho laith and N 27 ie ma er traume		19a. Informant's Name/Relationship (Type, Print) Mrs. Peggy Lee Tall Wh	Spous eatle	e 19b. y 21.	-	ess (Street and Number or Appleby Ave			Zip Code) 1.6 <b>1</b> 3
more	Pages 1 and of He out: if Item		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State	20b. Place of cometery Dorche	Disposition ( crematory of ster M	Name of prother place) Demorial Park		20c. Location - City or Cambridge	
Balti	permit. Departn Importe any inju	1	21 Air nature of Funeral Service Licensee	Ken	Merco.	Curra 308 H	n-Bromwell Figh St., Cam	uneral Hom bridge, MD	e,2PA	
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	Physician /Medical		resulting in death)	Acu;	Je Re	hal	failure			Onsot and Boats
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	uted 1 Insit	Examiner	cause. Enter Underlying		consequence of		earl- Dita	001		
,09	be executed sicien and burial-transit	ai Exa		to (or as a	consequence of	f):				
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ds, P.	uires that ( signed by d be deta	Ď	Part II. Other significant conditions contributing	o death but	t not resulting in	the underlyin	g cause given in Part I.		acco use contribute to	the cause of death?
Cor	8 2 6	Completed						24a. Was an autopsy	24b. Were au	topsy findings available
/g	iician: The iav certificate hes rector, page 2							perform 1 Yes 2	ned? death?	2□√0
-OIX	siciar s certif lirecto	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital:	Inpatient	t 2 ER/Out	nationt 2	Othor	eath (Check only one	·	
to uo	ding Phy h. After this funeral c	tion; T	27. Manner of Death 1 Natural 5 Pending	ate of Injury Month, Day			28c. Injury at Work?	28d. Describe how	nce 6 Other (Spec w injury occurred	:ny)
Who bivision	l or Atten after deat Director:	Certification:	3 Suicide 6 Could not be determined 28e. P	ace of Injur uilding, etc.	ry - At home, fare (Specify)			28f. Location (Stre City or Town,	eet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To 2 Medical Examiner: On the and one)	the best of e basis of e nanner state	examination and	death occurr or investigat	ed at the time, date and pla ion, in my opinion, death oc	ce, and due to the car curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	1 2	10		29c. License number		d. Date signed (Month	
			30. Name and address of person who completed of	1)		Type, Print)	1) 479	-4	1-18-0	/
-			NOMAN THANKY	300	D AURO		ST CAMBRI	DUE M	0 2161	3
	Sta Registr		31. Date filed (Month, Day, Year) 33.	2. Registrar	's Signature	K A	north			

**Physician** 

/Medical

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

HARRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

WRIGHT

4b. City, Town, or Location of Death

2. Date of Death Month

JANUARY

Year

2007

4c. County of Death

2234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registrar 31, perSCHD& 16aper fh, 1/27/07 Certificate of Death bg 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Grafton A.M **Physician** 1,20 09 ams 20 Norvanda /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Domerse Memori read a Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number Year) **Funeral** Hours Min 215-20-268 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23a or 28e-1 ehow any injury or other treumatic event, the Medical Examinar must be coulded any once. 10a. State 1 Yes 2 No Funeral Directo 10 2 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S Jones Rd 21817 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates: 2 🗆 No 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Deput Deputy Elementary/Secondary (0-12) College (1-4or 5+) Sheriff -aun er's Name (First, Middle, Maiden Sumame) 18. Moth 17. Father's Name (First, Middle, Last) Be ္ရ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rd. ristield, Md, 21817 Walter 26692 Jones inith Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 0 larion 4 Donation 5 DOther (Specify) FINCKSS HAME Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6. ware Hather HAMP diEnttuin 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 🗌 Yes 2 / No PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check on v one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) **IX** Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes 2 XNo Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D 48098 200 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2181 - Vijay Karumbunathan, M.D. 31. Date filed (Month, Day, Year) 32. Registrar State Registrar

4b. City, Town, or Location of Death Bethesda Suburban Hospital Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 918 5. Total Security Number **Funeral** 1∑M 2□F 413-12-7581 Director Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location Silver Spring in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Montgomery MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 820 Hillsboro Dr. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify δ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Phyiscist 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event opce. 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Zirkind Zicel Lifshitz 19a. Informant's Name/Relationship (Type, Print) Ann Zirkind / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 820 Hillsboro Dr., Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State f∑ Burial 2 ☐ Cremation 3 反 Removal from State King David Mem. Garden Jan. 22, 2007 Falls Church, VA \* 4 □ Donation 5 回 Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Linensee 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final intracranial hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events signed by the attending physician and d be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Ralph Zirkind 1/21/2007 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an performed? 1 Yes 2/2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Ø No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2. Date of Death

Jan. 21.

2007

4c. County of Death

USA

Black, White, etc.

Science

Month

White

3. Time of Death

1:36 P. M

9. Birthplace (State or Foreign New York

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Dav

1 ☐ Yes 2X No

Amend #5 Per FH 6866 4/09/09 Department of Health and Mental Hygiene
Certificate of Death
Reg. No.

ZIRKIND

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd ROQUE ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

29a, Certifier

(Check only one)

31. Date filed (Month, D

29b. Signature and title of certifier

30. Name and address of person who col-

For State Registrar

**Physician** 

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Ralph

4a. Facility Name (If not institution, give street and number)

2 3 2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Michael Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Time of Deat Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Michael Anthony Brown Month Day February 4, 2007 **Medical Examiner** 1719 hrs 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death St. Agnes Hospital Baltimore 8. Date of Birth (MM/17960) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 9. Birthplace (State of **Funeral** Months Days Hours Director -80-154 M 2 Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in y 28a-f show Yes 2 No with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever th u.s. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White\_etc hours after death 2 Never Married Married Yes Divorced If Yes, Give Year Yes 2 No specify: è 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) n and Mental Hygiene. 27 is marked other than "i matic event, the Medical E Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant; If item 27 is marked other than " Baltimore, MD 21215-0036 sales 0 17, Father's Name (First\_Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Cremation 3 Removal from State crematory or other place) Burial 2 Department or enreuter Donation 5 Other Specify Sign ture of Funeral Service Liqensee 22. Name and Address of Facility UBERT 110 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as condiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED x AMENDED ITEM#1, perPHYS., #6&7, perFH, g864, 2/7/07, WS Box 68760 the attending phys IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Month 3 Ectopic pregnancy Year Live birth Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. è 1 Yes 2 No 3 Probably 4 V Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate Yes 2 V No the Hospital or Attending Physician; 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other 4 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Inpatient this ို 1 V Yes No 28a. Date of Injury (Month, Day,Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🗸 Natural Director: Yes 2 No Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) To the Funeral Di determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. February 5, 2007 of person who completed cause of death (Item 23a) 30. Name and address, Jack Titus MĎ Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KTH Year Month Day 1 **Physician** FEBRUARY 04 2007 KOBERT BUNN /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Yrs. 71 Director 212-30-2778 07 06 Usual Residence of Decedent 10c. City, Town or Location the Maryland 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No 28a-f sh notified Baltimore Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. and 11 them 21 is amended other than "natural", or Items 23a or 3 and 11 them 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be no U.S.A. 21216 3001 Elgin Ave Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12th grade College (1-4or 5+) Self Employed Musician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charity Bullock Elias Bunn Sr. ဂ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informants vanishing Elizabeth
Betty Bunn-Wife 3001 Elgin ave, Baltimore, Md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any Injury or ot once. Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 2/12/07 owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Signature of Funeral Service L 21215 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIO disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an s certificate has b irector, page 2 st autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 the 29c. License number 29d. Date signed (Month, Ray, Year) 29b. Signature and title of certifier 241410 Telyzuazno la 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P HOSPITAL

Registrar DHMH 17 Rev 1/2001

State

MEATHWEST 31. Date filed (Month, Day, Year)

FEB 0 7 2007

CENTE

Registrar's Signature

	Dames		1- For State Registrar		- Waryland		artment of artificate of	f Health ar f Death	id Men	tal Hyg	,	Reg. No. 2	007	0348
Medic	Physic al Exan		Robbie		Len	etta		Bai	nes		Date of Dea Month January 2	ath		Time of Death 0409 hrs
(mark)	P.		4a. Facility Name (if n 726 N. Carrol	not institution, give s Iton Ave. Apt.	reet and number	er)		4b. City, Town, or Baltimore			oundary L	4c. County of	f Death	
	Funera Director		5. Social Security Nur	mber 6. Sex		Age (In yrs.	last birthday)	If Under 1 Yea			8. Date of Bi	rth (MM/DD/YYYY		lace (State or
	Directo		219-80-5 Usual Residence of D		2 XF	47	Yrs		's Hours		1/11/19	60	Foreign Count	ry) MD
	ow any			b. County		10c. City	, Town or Locati						1	Od Inside City Limits
	Maryland 28a-f show any d_at once.	Director	MD 10e. Street and Numb	Baltimo	re		Owing	s Mill:	<u> </u>			l0g Citizen of Wh		Yes 2 X No
	ith the 3.23a or notified	al Dir	104 Ench						1117			U.S	. A	
	flied within 72 hours after death with the Maryland I Hygiene. 4 Hygiene. 1. the Medical Examiner must be notified at once. 1. the Medical Examiner must be notified at once.	y Funeral	Never Married     Widowed	2 Married 1	es, Give Year		If Y	s Decedent of His es, specify Cubar Yes 2 No	spanic Origin, Mexican,  specify:	in? ( Speci Puerto Ric	ify Yes or No can, etc.)	White	etc.	Indian, Black,
	hours a 'natura	ted by	15. Decedent's Educ Elementary/Second	ation (Specify only i			16a. Decedent	t's Usual Occupat	ion (Give k	and of work	k done	16b. Kind of Bus		istry
036	ithin 72 ene. er than ' er dical	Completed	12th gra	de	College (1-4 or 2yrs	,	i	_			,	Obse		
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D 21;	2 should be h and Mental 27 is marke matic event	2	19a Informant's Name	Relationship (Type	Print )		19b. Mailing	Address (Stree	t and Numb	ber or Rura	Robin	nber, City or Town	State, Zir	Code)
0	and Healt Item	10.0	Sherone 20a Method of Dispos	ition		20b	Place of Disposi	tion (Name of cer	ed H	lills	Roa	Owings Apt 20c. Location - C		
Baltimore,	그 등 등 등		1 X Burial 2 4 Donation 5	Other Specify	Removal from S	tate	crematory or oth  Mt • Ca	armel		2/2/	07	Baltim	-	
Ball	permit Departn Import	كسسا	24 Storiature of Funer	al Service Licensee	Shall	lam	) Mai	ame and Address	of Facility Wes	t	D = 1 + .			
	ysician Nedical	/	23a. Fart I. Enter Ind d failure List only of	one cause on each i	ne.		. Do not enter th	e mode of dying,	such as car	rdiac or res	spiratory arre	imore, est, shock, or hear	A	21215 pproximate Interval Between Onset and
Fx	aminer		Immediate Cause (Fina or condition resulting in	- dde-	lateral to (or as a cons		pembolism f):							Death
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	.=	Examin	cause. Enter Underlying (Disease or injury that events resulting in dea	initiated C	to (or as a cons	equence of	f):							
	icate be executed physician and the burial - transit		X UNPENDED	d.	MENDED									
760,	physici the buric	/Medical	IF FEMALE: 23b. Was decedent preg	1 4	#7,8 per 3c. If yes, outco	FH, 23 me of pregr	a PII 27,	jerME, 986	4 2.21	.07 TI		23d Date of de	livery	
Box 68	the attending p	Physician/	past 12 months?	4	Live birth Pregnant at	time of dea	ath	al death 3 [ er (Specify)	Ectopic p	pregnancy		Month	Day	Year
D. Bo	by the att		Part II. Other significa			h but not re	esulting in the un	derlying cause gi	ven in Part	,	23e Dud tot	pacco use contribu	to to the a	auga of dooth?
s, P.O	n signed Id be del	ed by		n abscess:								2 No 3		
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of Vit	After this o	To B	examiner?  1 ✓ Yes 2  27. Manner of Death	No Hospi	ı inpatie		ER/Outpatient			Nursing Ho			Other Sce	ne
ion c	leath tor: Af the fun	ation	1X Natural 5	Pending Investigation	28a Date of Inju (Month, Day,Y	ear)	200. Time of Inju	·   · · ·	es 2 N		Describe ho	ow injury occurred		
Division of Vital Records, P.O. Box 687	24 hours after death Funeral Director: stely filled in by the	Certification:	3 Suicide 6	Could not be determined	28e. Place of In	jury - At ho	me, farm, street,	factory, office bu	ilding, etc.	28f.	Location (St or Town, Sta	reet and Number oate)	or Rural Ro	oute Number. City
le Hosni	in 24 hours he Funeral oletely filled		29a Certifier (Check only 1 Cert	tifying Physician:	o the best of m	y knowledg	e, death occurre	d at the time, date	and place	e, and due	to the cause	(s) and manner as	stated	
To the	within 24 To the F complete	Medical	29b. Signature and title	dical Examiner: On and of certified	manner stated	mination an	id/or investigatio	n, in my opinion,		rred at the		nd place, and due 29d Date signed	_	
				UN	V1. 1	1		O.C.M	.E.			January 20, 2		2,,700,,
	D	- 1	<ol> <li>Name and address of Jack Titus MD.</li> </ol>	Deputy Chie				Street, Baltin	nore, MI	D 21201				
	Sta Regist	ate rar	31 Date filed (Month)	3°7 2007	32. Registra	's Signatur		RI						

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2007 7:00 p February BESSIE JUANITA BEASLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CO BALTIMORE
If Under 1 Year If Under 24 Hrs. 11526 EASTERN AVENUE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Min. **Funeral** Months 1 □ M 2XX MARYLAND 83 AUG 16 1923 Director 218-22-5760 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Directo BALTIMORE MARYLAND BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 U.S.A. 11526 EASTERN AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK Baltimore, Maryland 21215-0036 ģ 3\CXWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Completed (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION TEACHER'S AID 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IDA PRESTON MAXWELL JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Haspert Rd., Apt F., Baltimore, Maryland 21236
Disposition (Name of Date 20c Location - City or Town State Mary L. Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State HOLLY HILLS MEMORIAL 02-09-07 MIDDLE RIVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee Ø now 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 44 -arcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown the 9 Unknown signed by the detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 Probably 4 Unknown 2 00 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autoosy has performed? Yes No page 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Nursing Home 6 ☐ Nursing Hom 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo ို 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Manner of Death Medical Certification: Injury To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide the trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar 31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blue, Rall Mo Zizi

32 Registrar's Signature

			For State Registrar	State of Ma	irylan			nt of He te of D				Reg. No	-001	03	483
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Wilbert		Bou	ldin					Date of De Month PDFUA	Ry 2	1,200	7 1/4	e of Death
ı	Examin		4a. Facility Name (If not institution, give MARY/AMC 676)	neral to	lospi	tal	B	y, Town, or	PORE	Cr	ty		. County of Dea		,
H	Funeral Director		5. Social Security Number 6. \$ 217–52–5033	9X 7. Ag	54 54	last birthday) Yrs.	Month.	er 1 Year S Days	If Under 2 Hours	Min. 8	Date of Bird (Month, Da 10—6	th ly, Year) 5–19:	9. Bir	thplace (Sta	te or Foreign 1d.
	yiand how		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	y, Town or Lo									e City Limits
	Ba-fs	Director		<b>JA</b>		Balt				-		10a Cit	izen of What C		HS 2 □ NO
	with the or 2	Dir	10e. Street and Number 2008 Bruid Hill	Avenue A	pt. I	R	101. 2	ip Code 2121	7			log. Cit	USA	ountry :	
٥	hours after deeth with the Maryland turet, or Items 23a or 28a-f show al Examinational be codified at	/ Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 XYes 2	Ever in U	S. 13.				jin? (Speci , Puerto Ri	fy Yes or No can, etc.)	-	14. Race - Ame Black, Whi		1,
215-0036	72 hours "natural", idical Exe	ed by	3 ☐ Widowed 4 ☒ Divorced  15. Decedent's Ed	Year or Dates:		16a. Dece	dent's U	sual Occupa	tion			16b. K	and of Business		
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altımore,	ges 1 and 2 t of Health If item 27 or other tra		20a. Method of Disposition  1 X Burial 2 Cremation 3		20b. F	Place of Disponentery, crea	sition (A	lame of r other place	9)	Dat	te	20c. Lo	ocation - City or	Town, State	9
	permit. Pages Department of It important: If ite any injury or of		<ul><li>'4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licer</li></ul>		M	d. Vet		M. and Address	1	2-8-0 Ma	rch F		ownsvil East	le, Mo	1.
R	Depi impo any i		> & lade	o Wo	na								e, Md.	21202	2
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Bue to (or as	ne. Utio a conseq Rati	uence of):	)	tmos tres		cardiac or i	respiratory a	rrest,		Approxi Interval Onset a	Between nd Death
27,09/80	icate be executed physician and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):									
O. Box	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	I death 3	⊒Ectopic ⊒ Other	pregnancy (specify)					23d. Date of de Month	blivery Day	Year
ds, P	uires that the de signed by the a ld be detached f	by	Part II. Dther significant conditions of	ontributing to death b	ut not res	ulting in the u	inderlyin	g cause give	n in Part I.		23e. Did t		use contribute t		of death?
Il Records,		Completed									24a. Was auto perfo 1 - Yes		death?	utopsy findir completion s 2 No	
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on of	ling Phys I. After this Tuneral di	ion: To	1 Yes 2 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju	ry	28b. Time of Injury		28c. Injury Work	4 🗆 190	28	d. Describe		6 Other (Spery occurred	эспу)	
Division of	To the Hospital or Attending Physician: within 24 hours after deals at the formation. To the Funeral Director: After this certified completely filled in by the funeral director; to	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 290 Place of Ini							f. Location ( City or To	Street ar wn, State	nd Number or R a)	lural Route I	Vumber,
	e Hospite 24 hours e Funera etely fille	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best niner: On the basis o and manner st	examina	owledge, deat ation and/or in	h occurr vestigat	ed at the tim on, in my op	e, date and pinion, deat	d place, an th occurred	d due to the d at the time,	cause(s date an	) and manner a d place, and du	s stated. e to the cau	se(s)
	To th within To th compl	Me	29b. Signature and title of certifier	94				29c. License	number 589			29d. Da	te signed (Mon 2/5/2(	th, Day, Yea	ir)
	144		30. Name and address of person who	completed cause of	eath (Iter	n 23a) (Type,	Print)	1 1	Sien	RIII	1.11	150	te signed (Mon 2/5/2( -tall		
	Sta	itė	31. Date filed (Month, Day, Year)	32. Registr	ar's Sign	ature	des !		. 4/	1 con	, , , , ,	-pr	1-0		

State of Maryland / Department of Health and Mental Hygiene [] For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:15 A M February 4 2007 Isaac Burroughs /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 754 - 216th Street Pasadena If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Jan. 7, 1 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 🖾 M 2 🗆 F Jan. 86 1921 137 14 6393 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County 23a or 28a-f show r then "neturel", or iteme 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Maryland Anne Arundel Pasadena Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 754 - 216th Street U.S.A. 21122 daath y Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 2 1 1 No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. 11 Marital Status fitad within 72 hours aftar 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) U.S. Printing Office Proof Reader other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) parmit. Pagas 1 and 2 should be fite Dapartment of Health and Mantal Hy Important: if Item 27 is marked other any liquy or other traumatic event once. Maurice Burroughs Elizabeth Banning 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 754 - 216th Street Pasadena, Maryland 21122 Frances Burroughs /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/2007 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) V onges time Heari **Physician** /Medical Due to (or as a consequence of) ALDIO MYO PATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 6 Year ARTERY DISRATA or Attending Physician: The law requires that the death certificate be axacuted burial-transit OCONARY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Be Completed by Physician/Medical ignad by the attending physical bardatached for use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
t □ Yes 2 □ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an autopsy performed?

1 Yes 2 No ours aftar daath.

nerai Director: Aftar this cartific
fillad in by tha funaral diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 LNO 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Complately filled: Hospitai 1(Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Doctor tywae MI) Attending 1041 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PASADENA, MD 21122 8021 RITCHIR HWY · V. CYRIAC. M-D 31. Date filed (Month, Day, Year) 32. Renistrar's Signature State FEB 0 Registrar 2007

DHMH 17 Rev 1/2001

07-00867 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Stephen Bonolis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day January 31, 2007 Michael Stephen Bonolis Medical Examiner 1839 hrs lc. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 11 McGuirk Drive Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Country) Mary Land Months Days Hours Min Director 219 84 8749 09/27/1960 1 X M 2 F 46 Usual Residence of Decedent 10c. City, Town or Location 'n 10a. State 10b. County 10d, Inside City Limits Anne Arundel Glen Burnie Yes 2 X No 28a-f show Maryland death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 663 Rhone Court 21061 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Ingian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Never Married Yes nours after Yes 2 X No specify: White Widowed Divorced f Yes. Give Year Specify: 'natural", ⋧ r Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed permit Pages I and 2 should be filed within 72 h
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "n
injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Baltimore, MD 21215-0036 Contractor Painting 17 Father's Name (First Middle Last) 18.Mother's Name (First, Middle, Maiden Surname) Ronald C. Bonolis Be Alice J. Greene 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Carolyn Bonolis / Wife 663 Rhone Court Glen Burnie, Maryland 21061 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 2/5/2007 Glen Burnie, Maryland 4 Donation 5 Other Specify. 21. Signature of Funeral Service I 22. Name and Address of Facility Gonce Funeral Service, P.A. hway Baltimore, Maryland 21225 4001 Ritchie Highway complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease Approximate Interval **Physician** failure. List only one cause on each line Retween Onset and /Medical Death Cirrhosis of liver Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Chronic alcoholism Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician or use as the burial 27. perME. g864, 2/21/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Dav Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? . death? ✓ Yes 2 No certificate 1 V Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 After this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? Manner of Death 28b. Time of Injury 28d Describe how injury occurred 1 X Natural 124 hours after death.

Funeral Director: A etely filled in by the fu Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30 Name and ad ress of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) State

Registrar

29b. Signature and title of certifier m

200

0 7

and manner stated

29c. License number OCME

February 1, 2007

29d. Date signed (Month, Day, Year)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

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	Funeral Director		5. Social Security Number 6.		(Cnt 62		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 3	1944 M	Birthplace (State or F County) aryland	oreign
	ed mi	7.	Usual Residence of Decedent  10a. State 10b. County  Md •		10c. City, T	own or Loc					10d. Inside City I	
	the Mi	ecto	10e. Street and Number		Ба	TLIII	10f. Zip Code		1	0g. Citizen of Wh		
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936	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mental Pyglene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show eny injury or other treumatic event, the Medical Examination and the notified at annex.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		1		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White	
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Z.	should nd Men marke umatic	٢	19a. Informant's Name/Relationship			19b. Mailing	Address (Street	Mary . and Number or Run	Jablons al Route Number		ate, Zip Code)	
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Divisi	in Diffe	Certification:	3 Suicide 6 Could not be determined	e One Bless of Init	ury - At home c. (Specify)	, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number , State)	or Rural Route Number	
	ne Hospital n 24 hours a ne Funerel f	edical C	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Example	nysicien: To the best miner: On the basis of and manner sta	examination	dge, death and/or inve	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the ca	use(s) and mann ate and place, and	er as stated. I due to the cause(s)	
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_	13			completed cause of d	eath (Item 23	a) (Type, P	n Ave I	S-000 Baltimo	re, MI	2122	4	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26 State Phylacological Perpenting of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1.. Decedent's Name (First, Middle, Last) Day -Month **Physician** ,20 ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Age (In yrs. last birthday) 6. Sex **Funeral** Min. Days Hours Months 231-22-4754 Usual Residence of Decedent 1 □ M 2 X F vorth Carolina Director with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State itam 27 is marked other than "naturel", or Itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2121 death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 12. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation e filed within 72 h al Hygiene. I other then "natu 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Stodia 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) armit. Pages 1 and 2 should be fill, apartment of Health and Mental Hy portant: If item 27 is marked oth y Injury or other traumatic event Be eemar reeman (Son) Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address 08 20b. Place of Disposition (Name of 20c. Location -20a. Method of Disposition permit. Pages 1
Department of H
Important: If its cemetery, crematory or other place, 1 Burial 2 Cremation Ridg 4 ☐ Donation 5 ☐ Other (Specify) dress of Facility 22. Name and 30. Seph 2222 W 21. Signatur of Funeral Service Licensee Funeral Home, P.A. W. North Ave. Balto. Md. 21 222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificete has been signed by the attending physicien and irrector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2 No After this certifice funeral director, p fo the Hospital or Attending Physician: 25 Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 20 1 🗌 Yes 1 Inpatient 2XXER/Outpatient 3□ DOA Residence 6 Other (Specify) No Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Division 5 Pending 1 Yes 2 No deeth. investigation within 24 hours after deeth To the Funerel Director: / correletely filled in by the f 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my onlinion, death occurred at the time. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Balt, Mo Name and address of person who completed cause of dilath (Italia 23a), (Type, Print) n

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year) 2007 32. Registrar's Signature

07-00869 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Tonya D. Brown-Lee State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day January 31, 2007 Medical Examiner 2054 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death University Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY Birthplace (State or oreign Months Days Hours Min Director Country) Usual Residence of Decedent 10a, State 10b. County Oc. City, Town or Location 10d. Inside City Limits Yes 2 No 28a-f show . Pages I and 2 should be filed within 72 hours after death with the Maryland fromt of Health and Mental Hygene.
renot: of Health and Mental Hygene.
renot: of teem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g Citizen of What Country 12. Was Decedent Ever in U.S. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married White, etc. Married Yes If Yes. Give Year Widowed 4 Divorced Yes 2 No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Busine Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Father's Name (First, Middle, Last Be City or Town, State, Zip Code) ဥ Place of Disposition (Name of cemetery crematory or other place) Cremation 3 Removal from State permit Page Department o Donation 5 Other Specify death. Do not enter Physician sease, or complica Approximate Interval allure. List of y one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Cardiomegaly with biventricular hypertrophy Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and be detached for use as the burial - trar Physician/Medical XUNPENDED 23a,pt11,27 per me g864 2-23-07 vt AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year 2 Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cocaine Use 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: completely filled in by the

Medical

30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature

determined

Homicide 29a. Certifier 1

Clet

29b. Signature and title of certifier

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

February 1, 2007

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\angle \cup \cup \angle$ Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last). bruacy ELAINE BURGESS 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Digai Hospital of Baltimore Poaltimor If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday, Months Days Hours Min 1 ☐ M 2 🗓 F 1-24-1953 MARYLÁND 54 218-56-0702 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No BALTIMORE MD. N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21215 USA 3302 W. BELVEDERE AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: BLACK 3 ☐ Widowed 4 ▼ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) -0-CHECK ORDERER -12-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNIE C. EDWARDS SAMUEL L. BURGESS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SAMUEL J. BURGESS (BROTHER) 2048 KNOTTY PINE DR. ABINGDON, MARYLAND 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 2-10-2007 WOODLAWN CEMETERY BALTIMORE, MARYLAND 21. Signature of Feneral Service Acepted JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1 En r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc., or heart failure. List only one cause on each line. Immediate Couse (Final disease or condition resulting in death) Due to (or as a considerate of): Due to (or as a consequence of): Sequentially list conditions, if any begins to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Inknown 1 Tyes 24a. Was an autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Knawn as

burial-transi and / attending physician for use as the burial been signed by t should be detach funeral director, After this To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Physician/Medical

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Completed

Be

Certification: To

P.O. Box 68760,

Division or Vital Records,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

	1X Yes 2 □ N	o 1 ☐ Yes 2
26. Place of Death (C	heck only one)	
Other: 4 Nursing Home	5 Aesidence	6 ☐Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

examiner? 1 Yes 2 No	Hospital: Impatient	2 ER/Outpatient	3□ DOA	Ot
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c.	Inju Wo
3 ☐ Suicide 6 ☐ Could not be determined		At home, farm, stree Specify)	et, factory, of	ffice

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier mo

Beliedere Aue Baltimore, MD

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

4

32 Registrar's Signature

2401

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death Decedent's Name (First, Middle, Last) Year Physician 7:53 A M Culpepper Februaru 2007 Eddie /Medical 4c. County of Death 4b. City, Town, or Location of Death, 4a. Facility Name (If not institution, give street and number Examiner Johns more HOOKINS N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe last birthday) **Funeral** Hours Months Days Min. TXW 2DF **GEORGIA** Director 254-64-4680 63 MAY 15 1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at ty∑Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 3249 PELHAM AVENUE 21213 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Notes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2KKNo Baltimore, Maryland 21215-0036 Specify Specify: BLACK <u>م</u> 3KWidowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) BALTO CO PUBLIC SCHS ENVIROMENTAL TECH llth grade is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental GERTRUDE TERRY EDDIE CULPEPPER SR. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 is
any injury or other trau 6604 SNOWBERRY CT., BALTIMORE, MARYLAND 21214 Giavanna Culpepper/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PRK 02-07-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. arbara Chlour 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final *5*0min Physician arrest cardiac /Medical resulting in death) Due to (or as a consequence of): Examiner 50 min arrhythmia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed 4 days rhabdomyolysis burial-tran attending physician for use as the buria Box 68760, 4 days Physician/Medical bilateral lower exmemin IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9☐Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 ☐ Yes certificate 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 Date of Injury (Month, Day Year) 2 ER/Outpatient 3 DOA 1 Tes Certification: To After this 27. Manner of Death 1 Natural 2 Accident funeral 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No the Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 1,2007 RES - 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar worse street

600 North

Registrar's Signature

camp

Melissa

31. Date filed (Month, Day, Year)

21287 - 9106

Baltimore, MD

07-00641
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Edward F. Comly	1	I- For State Registrar	State of N	Maryland		tment of ificate of		and I	Menta	l Hyg		eg. No. 20	10-	7 0349		
Physicia	n/	Decedent's Name (First, Market)	liddle,Last)							2.	Date of Dea Month	th Day Year		3. Time of Death		
Medical Examir		Edward Fran	k Comly	, Jr.							January 2	3, 2007		1047 hrs		
		4a. Facility Name (if not insti 615 E. Pulaski Hw		et and numbe	er)	1	lb. City, Tow Elkton	n, or Loc	cation of L	Jeath		4c. County of Cecil	Death			
Funeral		5. Social Security Number	6. Sex	7. /	Age (In yrs. las	st birthday)	If Under 1	<del></del>	If Under 2		8. Date of Bir	rth (MM/DD/YYYY)				
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121: d be fii ental J arked	Be	Edward F. C				10h Mailine	Addross (	- 1			L. Wal	.15 mber, City or Town	State	Zin Code)		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	Amy Hardy, D		•								oming, D				
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Physician /Medical		23a Part I Enter the diseas failure List only one of	ause on each lir	ne.					ich as car	diac or r	espiratory ar	rest, snock, or nea	1	Approximate Interval Between Onset and Death		
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Box 6876 e death certificate the attending phy ed for use as the te	sician/N	past 12 months?  1 Yes 2 No 9	4		t at time of dea	nath	ther (Specify	1)								
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/ita ysician his cer directo	o Be	examiner? 1 ✓ Yes 2 No	Hosp	ital: 1 Inp	atient 2	ER/Outpatien	3 DO	A O	ther <sub>4</sub>	Nursing	Home 5	Residence 6	Other:	Scene		
Division of Vital Records, tal or stending Physician: The law requirers after death all Director: After this certificate has been silled in by the funeral director, page 2 should to	-	27. Manner of Death		28a. Date of (Month, D	Injury ay,Year)	28b Time of	′ ′		at Work?	- 1	8d. Describe	how injury occurre	;d			
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Ospita I hours unera Iy fille	O	4 Homicide 29a. Certifier			of my knowledg	ne death occu	rred at the ti	me date	and plac	e and o	ue to the cau	use(s) and manner	as state	ed.		
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medica	I Examiner: On	the basis of	examination a	nd/or investiga	ation, in my o	pinion, d	death oca	urred at	the time, date	e and place, and di	ue to the	e cause(s)		
To To	Me	29b. Signature and title of		d manner_stat	ied.		29c	License	number			29d Date signe	d (Mor	nth, Day, Year)		
		Samet The	EHNII	nn				O.C.M	.E.			January 24	, 2007	7		
d		30. Name and address of p					(4 D= : - 2	24	D = 14:	nuc 11	D 24204	-				
		Pamela E. South			rrar's Signatu		11 Penn S	otreet,	Baltimo	ore, M	21201 ט					
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APON TIME 7 periff (364, 2/9/07 PS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Carter 4<sup>Day</sup> 200<sup>Y</sup>7<sup>ar</sup> 1:15a **Physician** George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore White Marsh Franklin Square Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month Day, Year) 7-23-1948 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Wash., D.C. 58 Months Days Hours Min. 231-68-8140 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h. County nt of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Md. NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 5631 Leiden Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2√ Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify. Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
Grad School Elementary/Secondary (0-12) Professor Morgan State Univ. 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unkn George Martha King R. Carter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5631 Leiden Road, Baltimore, Md. 21206 Wanda B. Carter Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2-6-07 Baltimore, Md. Greenmount Cem. 22. Name and Address of Facility March F.H. East 21. Signature of Funeral Service Licensee La 1101 E. North Ave., Baltimore, Md. 21202 wane 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one or up e on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 1 ☐ Yes this certificate 1□ Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ DOA မှ within 24 hours after useum.

To the Funeral Director: After th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury Natural Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

Registrar

State

O

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

2007

31. Date filed (Month, Day, Year)

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			1 - For State Registrar	State of	Marylan		artmen rtificat				ental Hy	gienę? Reg. No.	007	034	93
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 1:56 A M February Arthur W. Caliman /Medicat 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death 4c. County of Death Examiner Baltimore Charlestown Care Center Catonsville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/03/1913 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) **Funeral** Days Hours Min M 2□ F Yrs Director 123-22-3859 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23s or 28s-1 show any fulry or other traumatic event, the Medical Examinar must be notified at once. 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 709 Maiden Choice Lane 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify: Specify: Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Municipal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barbara Allen Arthur Caliman ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Br. Arthur Caliman CFX / Son 914 Stiles Street Baltimore, Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/07/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Signature of Funeral Service L 22. Name and Address of Facility David J. Weber Funeral Homes PA 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) ysician 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.0. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🔲 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ☐ No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural I hours efter death. unerel Director: Afi sly filled in by the fur 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number S 30. Name and address of rerson who completed cause of death (Item 23a) (Type, Print)  $\rho$ Marden 951 115 Choro Lane

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Moeth

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2. Registrar's Signature

2007

			For State Registrar	State of Marylan		artment of rtificate o			F	Reg. No.	007	03495	
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			HOWARD COUNTY	GENERAL			BIA, M				WARD		
	Funeral Director		5. Social Security Number 6. Sec. 214 24 1038	T. Age (In yrs.		If Under 1 Ye Months Day		Min.	Date of Birtl (Month, Day 22	/, Year)	Cou	place (State or Foreign ntry) nnsylvania	
	D D		Usual Residence of Decedent  10a. State 10b. County	100 Cit	v. Town or Lo	postion				1		10d. Inside City Limits	
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	r 28a-	Director	10e. Street and Number			10f. Zip Code	Э			10g. Citizer	n of What Cou	intry?	
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	- ms	Funeral	11, Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of If Yes, specify C	of Hispanic Orig uban, Mexican	gin? (Speci n, Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Amer Black, White		
36	be filed within 72 hours after death with the Maryland Hygiene.  I shall be seen to see the seen seen seen seen seen seen seen se	by Fu	1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 21 <b>€</b>	No Specify:			S	pec <i>ity:</i> Whi	te	
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Baltimore,	permit. Pages Depertment of Important: If i eny injury or once.		21. Signature of Funeral Service Licen		A 40	2. Name and Ad 001 Ritc	dress of Facilit	y Gond ghway	e Fund Balt	eral S imore	Service , Maryl	e, P.A. and 21225	
Y.	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between								Approximate Interval Between		
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	To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c. Lic	ense number	.1		29d. Date	signed (Month	Day, Year)	
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	3		30. Name and address of person who	- 4	11 23a) (Type	1 Neck	Road	Bal	limur	- 1	Vaufan	d 21221	
		ate	31. Date filed (Month, Day, Year)	32. Addistrar's Sign	ature	Carll 6							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 03 Year Chalew **Physician** Sidney 4:20 A M 2007 Feb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center NA Balhmore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday) Social Security Number 6. Sex 8. Date of Birth **Funeral** Hours 10/08/1915 1 M 2□ F 052-10-3951 91 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🙀 No Directo MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 1 GRISTMILL COURT #203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify: 3 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ SELF EMPLOYED LIQUOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ABRAHAM CHALEW COHEN HELEN ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 GRISTMILL COURT #203 - BALTIMORE, MD 21208 RALENE CHALEW / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 02/06/2007 RANDALLSTOWN, MD ion 5 ☐ Other (*Specify*) Funeral Service Lio n 4 □ Donation 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Cell Physician Non disease or condition resulting in death) Metastaho /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner burial-trar physician and resulting in death) Last Due to (or as a consequence of): by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed or Attending within 24 hours after death.

To the Funeral Director: A
completely filled in by the for Hospital

Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

(Check only

29c. License number 1855 Feb 03 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South

Green

Baltmore MD trut

32. Registrar's Signature

MP

and manner stated.

		•	For State Registrar	State of Maryla		artment of Heartificate of De		Reg. 1	C 0 0 1	0349/	
l.	Physicia /Medic	an	1. Decedent's Name (First, Middle, Las Kevin U	1:11:AM	Ī	unlear	1. 5	anucry	28 200 7	3. Time of Death	
2	Examin Funeral Director	er	4a. Facility Name (If not institution, give  Tohns Hopk 5. Social Security Number  169-48-4436	ins Huspi	last birthday,	If Under 1 Year II	t Under 24 Hrs. 8. [	Date of Birth	ar)   Count	ace (State or Foreign ry) York	
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or L	ocation			10	d. Inside City Limits	
	Ba-f sh	ctor	VA	S	Suffolk			10-	0::	1 ☑ Yes 2 ☐ No	
	with th	i Dire	10e. Street and Number 6200 Springhill	Way		10f. Zip Code 23435			Citizen of What Count USA	ry :	
036	of within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23a or 28a-f show tre Medical Examination the notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No 1	U.S. L978- 2006	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Specify Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - America Black, White, e Specify: Whi	itc.	
<u>2</u>	_ • =	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occupation kind of work done dur. DO NOT use retired)	on ing most of working	16b	. Kind of Business/Ind	ustry	
2121	il Hygiene. other then vent, it e Mer.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		US Air Force			Military		
Maryland 21215-0036	be filed Ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)			18	8. Mother's Name (Fil				
ryla	d 2 should I th and Meni 7 Is market treumatic	ဥ	John T. Dunleavy  19a. Informant's Name/Relationship (7)		19b. Mail	ng Address (Street and	Veronica d Number or Rural Ro	J		Code)	
	12 P P P P P P P P P P P P P P P P P P P		Linda L. Dunleav		6200	Springhil					
Baltimore,	uit. Pages 1 artment of He ortent: If Iter Injury or oth		20a. Method of Disposition  1 Surjet - 9 Cremation 3 4 Donation 5 Other (Specif)  21. Signiture of Fuheral Service Licen	Removal from State A	cemetery, cre rlingto ational	osition (Name of matory or other place) on Cemetery 2. Name and Address	2-27-20 of Facility Stu	007 A	Location - City or To Arlington, Funeral Ho	VA	
8	Department of the property of		23a. Part1. Enler the disease, or com	Allmour		690 Bridge			7A 23435	Approximate	
	Pnysician /Medical Examiner	ner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Septic  Due to (or as a conse  Due to (or as a conse	Sho	1			drome	Interval Between Onset and Peath A Ays	
68760,	icate be executed physicien and s the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Pestric Due to (or as a conse	equence of):	Carli	io-ngep	atry		2 years	
P.O. Box 6	The law re, uires that the death certificate as been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	stal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year	
	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given are are:						id tobacco use confribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown		
of Vital Records,	n: The law i ficete as b or, page 2 sh	e Completed	25. Was case referred to medical				26. Place of Death C	24a. Was an autopsy performed 1 Yes 2 2	prior to cor death?	psy findings available inpletion of cause of	
Ξ	ysicia is cert directo	To Be	examiner?	Hospital: 1 Inpatient 2	☐ EP/Outpatio	Other			e 6 ☐Other (Specif)	/)	
	Attending Ph ir death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Work?	at 28d es 2 □ No	. Describe how i	njury occurred		
Division	al or Atte s after des il Directo id in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete completely filled in by the funeral director, page	Medical C		ysician: To the best of my k niner: On the basis of exami and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifier	med Medi	cal Do	29c. License e		_	Date signed (Month,		
	10		30. Name and address of person who Shuhina Ahy	completed cause of death (If	tem 23a) (Type	Print)	-				
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Sig	gnature	fork)				1 21.	

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Physician /Medical Examiner

**Funeral** Director

"natural", or items 23a or 28a-f shor dical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23s er than "natura , the Medical E

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or ot

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhysician and in by the

Division or Vital Records, P.O. Box 68760

Month 2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give Arundel NNA (00W Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) ial Security Number Days Months 1**∏** M 2□ F Yrs. 30 1945 Maryland 216-42-3272 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Counfy TY Yes 2 □ No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 1914 A Copeland St. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give 1 968 – 70 Year or Dates: 968 – 70 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th A-Z Looseleaf Co. Forklift Driver ი 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Dodd Rachel Smith မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1914 A Copeland St. Annapolis, Md. 21401 Madelyn N. Dodd(Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 2-5-07 Maryland Veteran Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) WinName Release of & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Lany J. Ree M00483 23a. Part1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) teric so Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Year Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 1 ☐ Yes 2□ No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 FR/Outpatient 3 DOA 1 Yes 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEPILA ise of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Division or Vital Records, P.O. Box 68760,

	shock, or heart failure. List only	one cause on each line.	e mode of dying, such as cardiac d	or respiratory arrest,	Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death)	a. ASTHM	4		YEARS				
iminer		Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):							
	Cause (Disease or injury that initiated events resulting in death) Last	c							
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ea by Pr	Part II. Other significant conditions	contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown							
Complete				24a. Was an autopsy performed?	4b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
บั	25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
0	1 ☐ Yes 2,7 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		me 5 ☐ Residence 6 ☐	Other (Specify)				
ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	1	Work?	28d. Describe how injury oc	ccurred				
enilic	3 Suicide 6 Could not be 4 Homicide determined		actory, office	28f. Location (Street and No City or Town, State)	umber or Rural Route Number,				
CICAL	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.								
ĕ	29b. Signature and title of certifier		29c. License number	29d. Date si	gned (Month, Day, Year)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

1532

Md.

Black

21202

10d. Inside City Limits

1 Yes 2 No

State Registrar

FEB 0 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

1205

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL**